MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 27 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 09 | HOSPITAL DAY: 10

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400	1200	1600	2000	2400	0400									
BP ARTERIAL LINE	/	/			/	/									
BP CUFF	86/50	88/59	90/50	90/56	101/44	93/59									
TEMPERATURE	98.0	98.5	99.0	98.3	99.0	98.5									
PULSE	64	82	76	86	79	71									
RESPIRATORY RATE	16	16	18	18	14	16									
OXYGEN (L/%)	/	/			/	/									
PULSE OXIMETER	100	98	99	97%	99%	100%									
O_2 METHOD	RA	RA	RA	RA	RA	RA									

Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; MT = Mist tent; PR = Partial rebreather; A = Aerosol; TC = Trach collar

PAIN

TIME:	0700	1600	2200						
PAIN INTENSITY (10 / 5 / 0)	x	5	0						
MED ADMINISTERED (Y/N)	N	Y							
RELIEF ACCEPTABLE (Y/N)	NA	Y							

OTHER

TIME:	0700								
FINGER STICK GLUCOSE	N/A								
INSULIN (Y/N)	N								

SPECIAL NEEDS

TIME:	0700	1600	2200
*Skin breakdown prevention	NA	NA	NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: N/A

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted] b(6)-4

DIAGNOSIS: SIP ① parietal skull fx & epid hematoma

DRG: _____ ADMISSION DATE: 18 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. b(6)-2

	TIME: 0700 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ Ø c/o HA	☐ c/o HA	☐ Speaks no English
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ generalized weakness	☐ Generalized weakness	☐ generalized weakness
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ staples to scalp intact, S S/S of infection	☐ staples to (L) scalp incision intact No S/S infection	☐ (L) scalp c sutures & staples intact OTA
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ Ø/10	☐ c/o HA Tylenol 650mg PO	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑ (b)(6)-2	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0700 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
IV patency ✓ q 8 hr: Good	IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed: N/A	IV tubing changed:	IV tubing changed:
LOCATION CONDITION	LOCATION CONDITION	LOCATION CONDITION
IV Site #1:	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2: N/O	IV Site #2: NO Access
Comments: IV D/C'd in (R) FA.	Comments: Access	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: MCW TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

N/A

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME: 0700	1600	2300
ID band visible/legible	[redacted]	
Orient to environment prn		
Side rails (2/4) up		
Bed position low		
Call light within reach		

OTHER

Review & post lab results	[redacted]		
Notify MD abnormal labs			
Incontinent urine/stool	[redacted]		
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE:
PERCENT CONSUMED: 50%	PERCENT CONSUMED: 75%	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) (AMBULATE) BSC (BRP) CHAIR	BEDREST (AMBULATE) BSC BRP (CHAIR)	BEDREST AMBULATE BSC BRP CHAIR
	☒ SELF ☐ ASSIST # TIMES/SHIFT:	☐ SELF ☑ ASSIST # TIMES/SHIFT:	☐ SELF ☐ ASSIST # TIMES/SHIFT:

TEACHING

TIME: 0700 INITIALS: [redacted]	TIME: 1600 INITIAL: [redacted]	TIME: INITIALS:
CONTENT: - plan of care - importance of nutrition	CONTENT: Plan of care	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	b(6)-2 SIGNATURE	SHIFT
CIV b(6)-4 [redacted]	[redacted]	[redacted] OUTPAN	06-14
		[redacted]	2
		[redacted] 91WM10	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1600	① scalp	staples, intact no s/s infection	NA

SECTION IV - NOTES

1600: A&Ox3. Pain 4/10. Tylenol 650mg PO given [redacted] blw-2

continue to monitor.

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 28 Sept 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 10 | HOSPITAL DAY: 11

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1600	2000	1200	0400													
BP ARTERIAL LINE	/	/		/													
BP CUFF	83/53	101/61	90/60	82/50													
TEMPERATURE	98.6	98.2	98.2	99.1													
PULSE	76	73	66	70													
RESPIRATORY RATE	16	16	16	16													
OXYGEN (L/%)	/	/		/													
PULSE OXIMETER	99	100	99%	98%													
O2 METHOD	/	/		RA													

Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; MT = Mist tent; PR = Partial rebreather; A = Aerosol; TC = Trach collar

PAIN

TIME:	0730	1430	2330	1200	0400				
PAIN INTENSITY (10 / 5 / 0)	2	X	1	K					
MED ADMINISTERED (Y/N)		NA	N		N				
RELIEF ACCEPTABLE (Y/N)		NA	N/A		N/A				

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)	N/A								

SPECIAL NEEDS

TIME:	1430	0400
*Skin breakdown prevention	NA	N/A
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted] b(6)-4

DIAGNOSIS: SIP (L) parietal skull fx c epid-hematoma

DRG: _____ ADMISSION DATE: 18 Sept 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____ b(6)-2 [redacted]

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE *Page 1 of 4 pages* MC V1.00

MEDCOM - 19445

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

D(6)-2

	TIME: 1000 INITIALS: [redacted]	TIME: 1430 INITIALS: [redacted]	TIME: 2300 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ Does not speak english	☐ Communication difficult. Speaks no English.	☐ language barrier
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑ Little PO intake.	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑ Walks S assistance Ambulated x 1	☑	☐ resting in bed
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Staples & Suture intact to scalp & drainage	☐ Incision to ⑤ scalp. staples intact.	☐ ☒ Scalp incision
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☑	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: _____	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: NO	IV tubing changed: _____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: _____	IV Site #1: _____	IV Site #1: _____
IV Site #2: NO	IV Site #2: Access	IV Site #2: _____
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: / TIME:							
COLOR							
CAPILLARY REFILL							
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE							

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	1000	1430	2300
ID band visible/legible			
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Shake	TYPE:
PERCENT CONSUMED: 25%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED:
☑ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☑ SELF ☑ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 1430 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: Plan of Care; Importance of Eating	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
[redacted] b(6)-4	b(6)-2	[redacted]	D
			2
			N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1430	(B) Scalp	staples intact, No s/s infection.	
	23 00	(L) Scalp	staples intact clean.	Ø. OTA

SECTION IV - NOTES

1430: Awake + Alert. No c/o pain or discomfort @ this time will continue to monitor. [redacted] RIA

b(6) ; 2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 29Sep03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 11 | HOSPITAL DAY: 12

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:																	
BP ARTERIAL LINE																	
BP CUFF																	
TEMPERATURE																	
PULSE																	
RESPIRATORY RATE																	
OXYGEN (L/%)																	
PULSE OXIMETER																	
O_2 METHOD																	

Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; MT = Mist tent; PR = Partial rebreather; A = Aerosol; TC = Trach collar

PAIN

TIME:	0700							
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N							
RELIEF ACCEPTABLE (Y/N)								

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:			
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

CIV [redacted] b(4)-4

qfgan

DIAGNOSIS: S/P Occipital skull fx c epidural hematoma

DRG: _____ ADMISSION DATE: 18Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: Armando Tefft

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. b(4)-2

	TIME: 0900 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ does not speak English Sutures/Staples removed from Scalp	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ unsteady gait at times	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: _____	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: _____	IV tubing changed: _____
LOCATION CONDITION	LOCATION CONDITION	LOCATION CONDITION
IV Site #1: ACC _____	IV Site #1: _____	IV Site #1: _____
IV Site #2: NO _____	IV Site #2: _____	IV Site #2: _____
Comments:	Comments:	Comments:

CIV [redacted] b(4)-4

MEDCOM - 19450

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE:	TIME:						
COLOR							
CAPILLARY REFILL							
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE							

N/A

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

	TIME: 0900			
ID band visible/legible	[redacted]			
Orient to environment prn				
Side rails (2/4) up				
Bed position low				
Call light within reach				

OTHER

Review & post lab results				
Notify MD abnormal labs				
Incontinent urine/stool				
Linen change prn	[redacted]			
Turn/reposition q2h				
ROM q2h if immobile				
Antiembolic hose				

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE:
PERCENT CONSUMED: 25%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST ~~AMBULATE~~ BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT:	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE b(6)-2	SHIFT
b(6)-4 CIV [redacted]	[redacted]	[redacted]	0

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1100 - Pt to RTD tent. Does not speak English at times has unsteady gait. [redacted] b(6)-2

CIV [redacted] b(6)-4

MEDCOM - 19452

Emergency

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.

1. AGE: 20's
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): nkda

3. PREVIOUS SURGERY [ ] NO [ ] YES (type): unknown

4. PROPOSED SURGICAL PROCEDURE: craniotomy

5. ADDITIONAL INFORMATION: Last PO: ? Medical Hx: see H+P Implants: ? Medications: ?
Jewelry removed: (yes)/no Family waiting: yes/(no)
ring

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; ~~family separation~~; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)

[redacted] b(6)-4

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.01

MEDCOM - 19453

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT IAN 18 Sept 03 DATE

11. POSTOPERATIVE EVALUATION:

Brie Site:

Drsg:

Breathing: intubated

D/W - 2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT IAN

DATE: 18 Sept 03 TIME: 2040

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT IAN

DATE: 18 Sept 03 TIME:

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2

3. DATE 18Sept03 TIME PATIENT ARRIVED IN SUITE 2050

4. PATIENT IN ROOM TIME 2050 NUMBER Trauma-1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] SSG [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☒ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Pt positioned on beanbag, left side up, axillary roll in place, head on sheets and foam donut, Lt arm on padded armboard + Lt arm on pillow, pillow between legs, all pressure areas padded, position approved by surgeon + anesthesia

8. SKIN PREPARATION

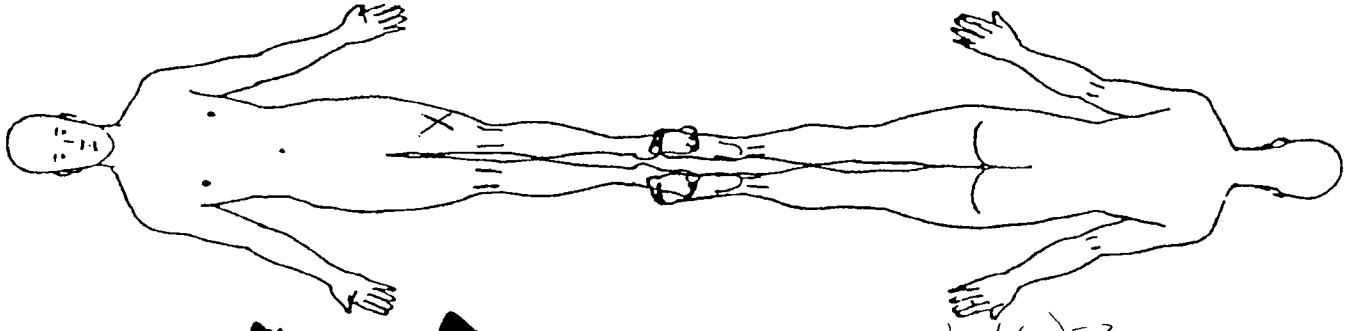
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☒ NURSING UNIT IEMT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Betal Beta b(6)-2
SITE: Occipital + Temporal BY WHOM: [redacted]
SITE: Lt side head BY WHOM:

COMMENTS: no pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] === Tourniquet b(6)-2

C = Correct I = Incorrect Initial: [redacted]

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☐ Yes ☒ No	NA	NA	NA	NA	NA
Other	☐ Yes ☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: Valleylab Force 2 #1
GROUND PAD: BRAND VL Pow Pflex II
LOT NO: 68936 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☒ BIPOLAR NO: Valleylab Force 2 #1

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

13. PROSTHESIS, IMPLANTS ☒ YES ☐ NO — IF YES NAME: ID NUMBER; MANUFACTURER

Craniofacial Plating System 81.2002 x 3 81.2054 x 1
Biplane CMS 0222403
4mm screw 81.2058 x 19
5mm screw 81.2059 x 1

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☒ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Lidocaine c Epi 1:100,000	15cc	I10	Inj	[redacted]	[redacted]
Thrombin 5000 u	QS	I10	Topical		
					b(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY
Gelfoam	I10	[redacted]
Surgicel	I10	
		b(6)-2

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	10mm JP Drain		
SITE	Posterior Head		

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
Kerlix
Tape

19. ADDITIONAL INFORMATION
WC II
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General

50150 → 35135
Bovie Pad site intact pre-op ✓; post-op_____ Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op_____: post-op_____ N/A
Tourniquet Time: Up____ Down_____

20. OPERATION(S) PERFORMED
Left Temporal Craniotomy for EDH

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-1 (CT scanner)	See DA7389	Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT I. MEDCOM - 19456

REVERSE [redacted] USAPA V1.01

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Sep DAY 21 22 23 24 25 26

1[redacted]2003 HOUR 12 12 12 12 12 12

PULSE (O) | TEMP. F (°)

PULSE (O)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICWZ

C[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 19457

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR Sep	DAY	27	28	29				
19 2003	HOUR	0600 1800	1600 2118	0949				

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

CIV [redacted]

b(6)-4

MEDCOM - 19458

[redacted] b(6)-4

ICU

SPECIMEN/LAB RPT. NO.

MISC

URGENCY
☒ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b(6)-2

REPORTED BY

MD
TECH

DATE 19 Sep 03 0400

LAB ID NO.

REMARKS Coags, Chem 8

TEST(S)
SPECIMEN TAKEN
DATE
TIME A.M. P.M.
REQUESTED
RESULTS

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

557-107

[redacted] b(6)-4

ICU

SPECIMEN/LAB RPT NO.

HEMATOLOGY

URGENCY
☒ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE
☐ VEIN ☐ CAP
☐ OTHER (Specify)

PATIENT'S MED. RECORD

b(6)-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUEST[redacted]

REPORTED BY

MD
TECH

DATE 19 Sep 03 0400

LAB. ID. NO.

REMARKS CBC

TEST(S)
SPECIMEN TAKEN
DATE
TIME A.M. P.M.
RESULTS
REQUESTED (X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT: CONTROL, PATIENT
CONTROL
PATIENT
% ACTIVITY
RATIO
SICKLING TEST
LE PREP

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

549-107

STANDARD FORM 545 (REV 10-75)
545-108

LABORATORY REPORT DISPLAY

20SEP03 0400

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____28 mmol/L

At 37C

PH_____7.512

PCO2_____33.5 mmHg

PO2_____187 mmHg

HCO3_____27 mmol/L

BEecf_____4 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

20SEP03 04:31

Oper: [redacted]

Physician:_____ b(6)-2

Ser# [redacted]

Ver: [redacted]

---

i-STAT EG7+ 1480 1800

Pt [redacted]

Pt Name:_____

Na_____140 mmol/L

K_____3.4 mmol/L

TCO2_____26 mmol/L

iCa_____1.18 mmol/L

Hct_____30 %PCV

Hb*_____10 g/dL

*via Hct

At 37C

PH_____7.461

PCO2_____34.7 mmHg

PO2_____191 mmHg

HCO3_____25 mmol/L

BEecf_____1 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

PH_____7.453

PCO2_____35.6 mmHg

PO2_____194 mmHg

Patient Temp: 99.6F

FIO2_____: 40

Sample Type_: ART

19SEP03 18:01

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

---

① ② ③ ④

ALIGN ALL LABORATORY REPORTS ALONG THIS BASE LINE

INSTRUCTIONS: This form may be used to display laboratory reports as a flow sheet to be read as a progressive table. If so, a separate sheet should be used for each type of report form. When assorted report forms are mounted on the display sheet, both test names and results should always be visible.

ENTER IN SPACE BELOW: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

[redacted] b(6)-4

FORMS DISPLAYED ON THIS SHEET ARE MOUNTED ON STRIPS 1 THROUGH 3

- ☐ CHEMISTRY I (SF 546)
- ☐ CHEMISTRY II (SF 547)
- ☐ CHEMISTRY III (SF 548)
- ☐ HEMATOLOGY (SF 549)
- ☐ URINALYSIS (SF 550)
- ☐ SEROLOGY (SF 551)
- ☐ SPINAL FLUID (SF 555)

MOUNTED ON STRIPS 1, 4, AND 7

- ☐ MICROBIOLOGY I (SF 553)
- ☐ MICROBIOLOGY II (SF 554)
- ☐ MISCELLANEOUS (SF 557)
- ☐ ASSORTED FORMS

Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45, 505

LABORATORY REPORT DISPLAY

☆U.S. GOVERNMENT PRINTING OFFICE : 1990 267-126

MEDCOM - 19460

======= PICCOLO =======

22/09/03 04:36

REFERENCE RANGE: MALE

PATIENT #: [redacted] b(a)-4

BASIC METABOLIC

DISC LOT #: b(a)-2 3145AA1

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	122*	73-118	MG/DL
BUN	6*	7-22	MG/DL
CA++	9.0	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	137	128-145	MMOL
K+	3.6	3.3-4.7	MMOL
CL-	101	98-108	MMOL
tCO2	23	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

======= PICCOLO =======

19/09/03 04:12

REFERENCE RANGE: MALE

PATIENT #: [redacted] b(a)-4

METLYTE 8

DISC LOT #: b(a)-2 3141AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	182*	73-118	MG/DL
BUN	14	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	392*	39-380	U/L
NA+	136	128-145	MMOL
K+	4.1	3.3-4.7	MMOL
CL-	113*	98-108	MMOL
tCO2	20	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

======= PICCOLO =======

20/09/03 05:21

REFERENCE RANGE: MALE

PATIENT #: [redacted] 1/(a)-4

BASIC METABOLIC

DISC LOT #: 3145AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted] b(a)-2

GLU	137*	73-118	MG/DL
BUN	4*	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CRE	0.6	0.6-1.2	MG/DL
NA+	132	128-145	MMOL
K+	3.8	3.3-4.7	MMOL
CL-	108	98-108	MMOL
tCO2	24	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

[redacted] b(6)-4 ICU 1

MISC

SPECIMEN/LAB RPT. NO.

URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

SPECIMEN SOURCE (Specify)

PHYSICIAN'S COPY

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN [redacted] b(6)-2

REPORTED BY MD / TECH

DATE 20 Sep 03

LAB ID NO.

REMARKS

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. / P.M.	REQUESTED	RESULTS

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

557-107

Air [redacted] b(6)-4 ICU 1

CHEM 1

SPECIMEN/LAB. RPT. NO.

URGENCY
☐ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

PATIENT STATUS
☐ BED ☐ AMB
OUTPATIENT ☐
☐ NP ☐ DOM

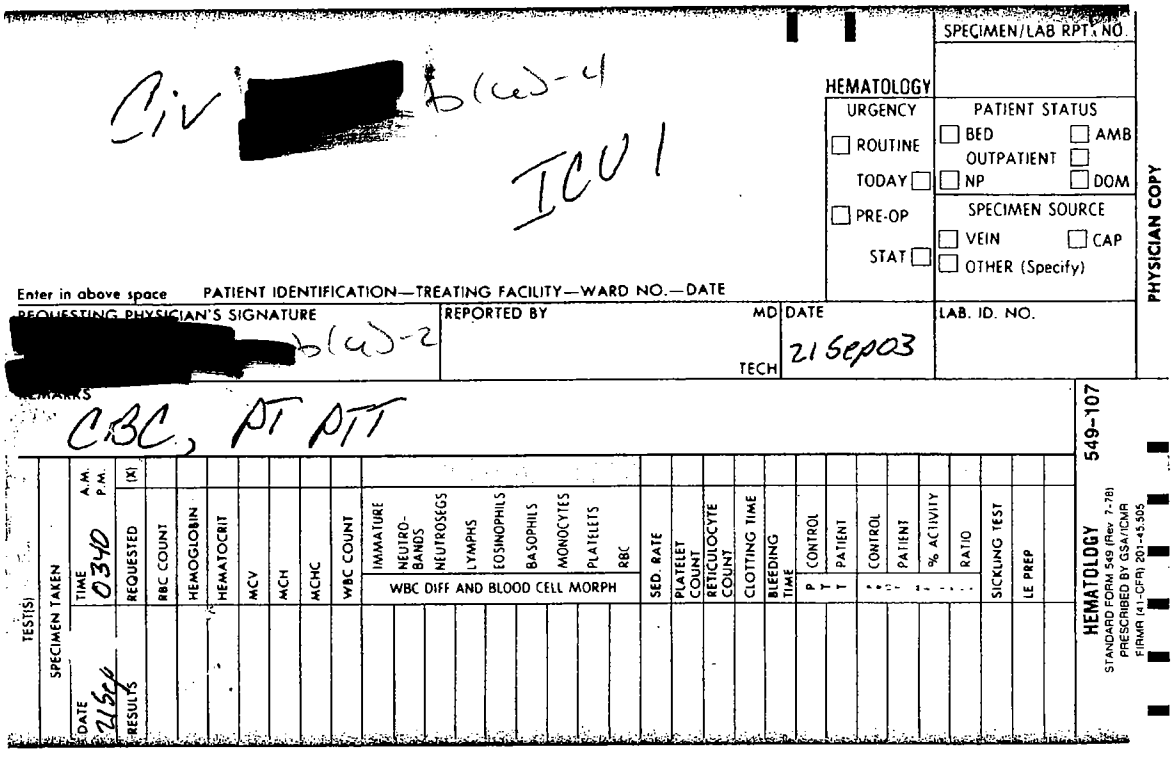
SPECIMEN SOURCE
☐ BLOOD

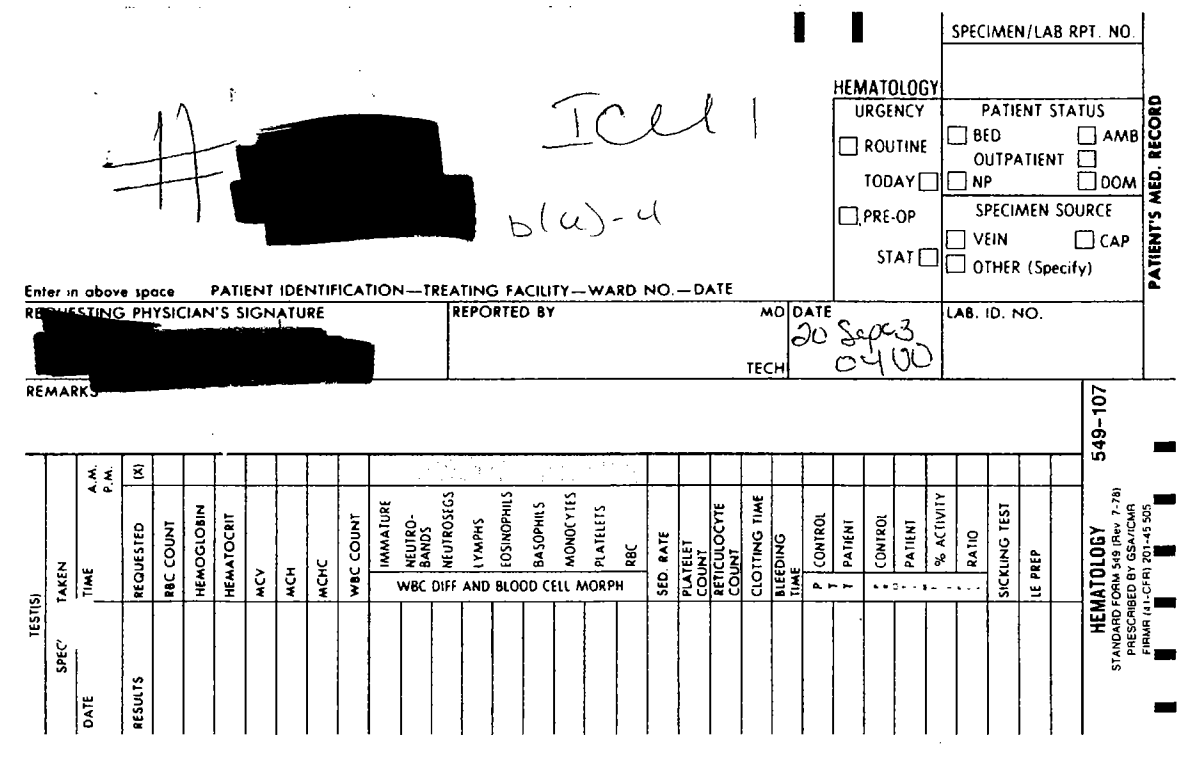
LABORATORY FILE

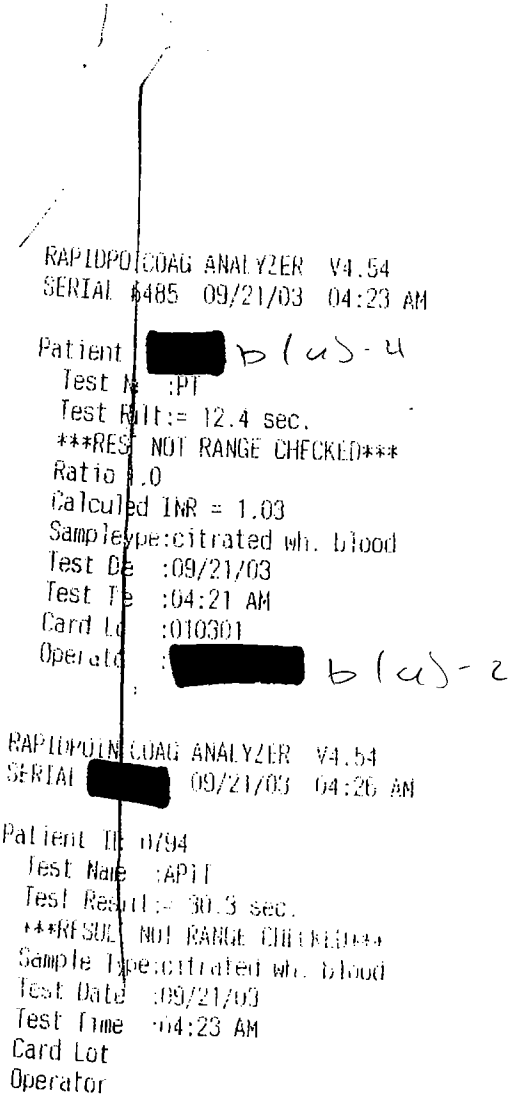
====== PICCOLO ======
21/09/03 04:19
REFERENCE RANGE: [redacted] b(6)-4 MALE
PATIENT #: [redacted]
METLYTE 8 3141AA4
DISC UNIT #: [redacted] b(6)-4 DR #: 000
OPER #: [redacted]
SERIAL #: [redacted]

GLU	131*	73-118	MG/DL
BUN	3*	7-22	MG/DL
CRE	0.5*	0.6-1.2	MG/DL
CK	485*	39-380	U/L
NA+	132	128-145	MMOL
K+	3.4	3.3-4.7	MMOL
CL-	106	98-108	MMOL
tCO2	23	18-33	MMOL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0


Civ [redacted] b(4)-4
ICU 1
HEMATOLOGY
SPECIMEN/LAB RPT. NO.
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE
VEIN
CAP
OTHER (Specify)
PHYSICIAN COPY
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE [redacted] b(4)-2
REPORTED BY
MD
TECH
DATE 21 Sep03
LAB. ID. NO.
REMARKS
CBC, PT PTT
TEST(S)
SPECIMEN TAKEN
DATE
TIME 0340
A.M. P.M.
RESULTS
REQUESTED (X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH
IMMATURE
NEUTRO-BANDS
NEUTROSEGS
LYMPHS
EOSINOPHILS
BASOPHILS
MONOCYTES
PLATELETS
RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT CONTROL
PTT PATIENT
PT CONTROL
PT PATIENT
% ACTIVITY
RATIO
SICKLING TEST
LE PREP
549-107
HEMATOLOGY
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505


[redacted] ICU 1
b(4)-4
HEMATOLOGY
SPECIMEN/LAB RPT. NO.
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE
VEIN
CAP
OTHER (Specify)
PATIENT'S MED. RECORD
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE [redacted]
REPORTED BY
MD
TECH
DATE 20 Sep03 0400
LAB. ID. NO.
b(4)-2
REMARKS
TEST(S)
SPECIMEN TAKEN
DATE
TIME
A.M. P.M.
RESULTS
REQUESTED (X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH
IMMATURE
NEUTRO-BANDS
NEUTROSEGS
LYMPHS
EOSINOPHILS
BASOPHILS
MONOCYTES
PLATELETS
RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT CONTROL
PTT PATIENT
PT CONTROL
PT PATIENT
% ACTIVITY
RATIO
SICKLING TEST
LE PREP
549-107
HEMATOLOGY
STANDARD FORM 549 (Rev 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505


RAPIDPOINT COAG ANALYZER V4.54
SERIAL #485 09/21/03 04:23 AM

Patient [redacted] b(a)-4
Test Name :PT
Test Result:= 12.4 sec.
RESULT NOT RANGE CHECKED
Ratio 1.0
Calculated INR = 1.03
Sample Type:citrated wh. blood
Test Date :09/21/03
Test Time :04:21 AM
Card Lot :010301
Operator [redacted] b(a)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/21/03 04:26 AM

Patient ID 0794
Test Name :APTT
Test Result:= 30.3 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/21/03
Test Time :04:23 AM
Card Lot
Operator

i-STAT GS+

Pt: [redacted]

Pt Name:_____

TCO2_____21 mmol/L

At 37C

pH_____7.317

PCO2_____39.5 mmHg

PO2_____180 mmHg

HCO3_____20 mmol/L

BEecf_____-6 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

19SEP03 04:08

Oper: [redacted] b(6)-2

Physician:_____

Ser# [redacted]

Ver: [redacted]

P TREND 09/21/03

		SpO2	SYS / DIA - MEAN	RR
		%	mmHg	RPM
		96	91 / 54 68	25
		93	112 / 72 87	20
		OFF	98 / 65 78	18
		OFF	108 / 65 82	24
10:01	106	97	105 / 63 82	22
09:00	78	97	104 / 61 74	OFF
08:00	90	97	104 / 60 75	OFF
07:00	79	98	116 / 58 79	OFF

ADULT

PROTOCOL

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/19/03 04:15 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :04:13 AM
Card Lot :010301
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/20/03 04:55 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 12.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 0.99
Sample Type:citrated wh. blood
Test Date :09/20/03
Test Time :04:55 AM
Card Lot :010301
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/20/03 05:00 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 24.0 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/20/03
Test Time :04:57 AM
Card Lot :100208
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/19/03 04:18 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 39.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :04:15 AM
Card Lot :100208
Operator : [redacted]
b(6)-2

[redacted] bles-4
ICU 2
Chem 7
22 Sept 03
0410

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

URGENCY: ☒ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☒ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENTS MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY MD / TECH | DATE 22 Sept 03 | LAB. ID. NO.

REMARKS Chem 7

549-107

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	(X)	RESULTS
REQUESTED				
RBC COUNT				
HEMOGLOBIN				
HEMATOCRIT				
MCV				
MCH				
MCHC				
WBC COUNT				
WBC DIFF AND BLOOD CELL MORPH: IMMATURE				
WBC DIFF AND BLOOD CELL MORPH: NEUTRO-BANDS				
WBC DIFF AND BLOOD CELL MORPH: NEUTROSEGS				
WBC DIFF AND BLOOD CELL MORPH: LYMPHS				
WBC DIFF AND BLOOD CELL MORPH: EOSINOPHILS				
WBC DIFF AND BLOOD CELL MORPH: BASOPHILS				
WBC DIFF AND BLOOD CELL MORPH: MONOCYTES				
WBC DIFF AND BLOOD CELL MORPH: PLATELETS				
WBC DIFF AND BLOOD CELL MORPH: RBC				
SED. RATE				
PLATELET COUNT				
RETICULOCYTE COUNT				
CLOTTING TIME				
BLEEDING TIME				
PTT: CONTROL				
PTT: PATIENT				
% ACTIVITY: CONTROL				
% ACTIVITY: PATIENT				
% ACTIVITY: RATIO				
SICKLING TEST				
LE PREP				

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
FIRMR (41-CFR) 201-45.505

ID: [redacted]
WB

20-09-03
04:56

			Patient Limits	
WBC	8.0	x10^3/uL	4.5	10.5
RBC	3.89 L	x10^6/uL	4.00	6.00
Hgb	11.4	g/dL	11.0	18.0
Hct	34.7 L	%	35.0	60.0
MCV	89.1	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	33.0	g/dL	33.0	37.0
Plt	175.	x10^3/uL	150.	450.
LY%	17.3 L	%	20.5	51.1
LY#	1.4	x10^3/uL	1.2	3.4

ID: [redacted]
WB

19-09-03
04:14

			Patient Limits	
WBC	10.1	x10^3/uL	4.5	10.5
RBC	3.98 L	x10^6/uL	4.00	6.00
Hgb	11.8	g/dL	11.0	18.0
Hct	35.7	%	35.0	60.0
MCV	89.7	fL	80.0	99.9
MCH	29.5	pg	27.0	31.0
MCHC	32.9 L	g/dL	33.0	37.0
Plt	202.	x10^3/uL	150.	450.
LY%	12.7 *L	%	20.5	51.1
LY#	1.3 *	x10^3/uL	1.2	3.4

b(6)-2

Ward/Section: EMT OR	REQUESTING PHYSICIAN: DR. [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE: 9/18/03 TIME: 2148	SSN/PSEUDO SSN: # [redacted] b(6)-4

i-STAT

TEST	RESULT	REF. RANGE

Pt Name: [redacted]

Na_____140 mmol/L
K_____3.7 mmol/L
TCO2_____19 mmol/L
iCa_____1.04 mmol/L
Hct_____30 %PCV
Hb*_____10 g/dL
*via Hct

At 37C
pH_____7.392
PCO2_____29.1 mmHg
PO2_____487 mmHg
HCO3_____18 mMol/L
BEecf_____-7 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.392
PCO2_____29.1 mmHg
PO2_____487 mmHg

Patient Temp: 37.0C
FIO2_____100
Sample Type: ART

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: CMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST: # [redacted] b(6)-4	DATE: 18 Sep 03	TIME: 1920
		SSN/PSEUDO SSN: # [redacted] b(6)-4

Pt: [redacted]
Pt Name:_____

Na_____145 mmol/L
K_____3.7 mmol/L
TCO2_____16 mmol/L
iCa_____1.00 mmol/L
Hct_____26 %PCV.
Hb*_____9 g/dL
*via Hct

At 37C
pH_____7.363
PCO2_____27.4 mmHg
PO2_____473 mmHg
HCO3_____16 mmol/L
BEecf_____-10 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.367
PCO2_____27.1 mmHg
PO2_____471 mmHg
Patient Temp: 36.7C
FIO2_____: 75
Sample Type_:

16SEP03 22:2(

Oper: [redacted]

Physician:_____

Ser# [redacted]

SR

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

PICCOLO
18/09/03 19:33
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-3
LIVER PANEL PLUS
DISC LOT #: 3122BA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-3 [redacted]

ALB	4.3	3.3-5.5	G/DL
ALP	75	26-84	U/L
ALT	26	10-47	U/L
AMY	48	14-97	U/L
AST	43*	11-38	U/L
TBIL	1.3	0.2-1.6	MG/DL
GGT	9	5-65	U/L
TP	7.9	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

PICCOLO
18/09/03 19:33
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: b(6)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	138*	73-118	MG/DL
BUN	26*	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	541*	39-380	U/L
NA+	139	128-145	MMOL
K+	4.1	3.3-4.7	MMOL
CL-	106	98-108	MMOL
tCO2	20	18-33	MMOL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

DATE: 18 Sep 03	LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE 18 Sep 03	TIME 1920

SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph %		
(Hemato		

ID: [redacted] 18-09-03
WB 19:38

			Patient Limits
WBC	13.7 H	x10^3/uL	4.5 10.5
RBC	5.37	x10^6/uL	4.00 6.00
Hgb	15.6	g/dL	11.0 18.0
Hct	47.6	%	35.0 60.0
MCV	88.6	fL	80.0 99.9
MCH	29.0	pg	27.0 31.0
MCHC	32.7 L	g/dL	33.0 37.0
Plt	282.	x10^3/uL	150. 450.
LY%	6.5 *L	%	20.5 51.1
LY#	0.9 *	x10^3/uL	1.2 3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

REMARKS:

REPORTED BY:

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Hazy	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	large	Negative
SG	1.030	N/A
Bld	Trace	Negative
pH	6.0	N/A
Prot	Trace	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 15.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated I[redacted]
Sample Type:citrated wh. blood
Test Date :09/18/03
Test Time :08:23 PM
Card Lot :010301
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/18/03 08:28 PM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 27.9 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/18/03

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Actest - Large
Rbc - 5-10
mucus - mod

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

nit Crossmatch
H EVERY UNIT OF BLOOD
ESTED)

DE	CROSSMATCH

b(6)-4

Ward/Section: ICU 2	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted]	DATE 21 Sept 03 / TIME 0400	SSN/PEEUDO SSN # [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		
GL		
BU		
CRI		
CK		
NA+		
K+		
CL-		
tCO2		

======= PICCOLO =======
26/09/03 04:14
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	117	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	43	39-380	U/L
NA+	~~120*~~ 131	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	89*	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP +, ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/dl
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
TB		3.3-5.5 g/dl
AP		26-84 u/l
AT		10-47 u/l
T		14-97 u/l
Y		11-38 u/l
L		0.2-1.6 mg/dl
		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

RESULT	REF. RANGE
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

REMARKS:

REPORTED BY: **DATE**

Ward/Section: 1CW2	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	DATE 28 Sep 03 / TIME 0710	SSN/PEEUDO SSN: [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

PICCOLO
09/28/03 07:57 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-4 [redacted]

GLU	109	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	26*	39-380	U/L
NA+	118*	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	92*	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

CL^-			98-108 mmol/l
tCO2			18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	DATE: 9-28-03	LAB ID NO.:

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS, SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)											TOTALS
Fentanyl (mcg)	50	<150?		50	50						300
Lidocaine (mg)	100										100
STP (mg)	500										500
Sux (mg)	120										120
VCB (mg)		5 ~ 5		5				5			20
VOLAT AGENT ISO % del		0.4	0.4	0.8	1.0	1.0	0.6	0.4	0.4	0.4	0.4
% e.t.											
AIR L/Min											
N2O L/Min											
O2 L/Min	10~	2	2	2	2	2	2	2	2	2	2	10

TOTAL EBL: 500

TOTAL URINE: 800

FLUIDS SUMMARY
CRYSTALLOID- 6.5L
COLLOID- 0
BLOOD- 1 unit

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: P P P P ... P P

FLUIDS
LINE site 14G (R) ☐ Warmed — NS#1 —— 1000 #5-#7 —— NS LR 2L } LR- 2L
18G (L) AC ☐ Warmed — LR#2 —— 600
(R) IJ cordis ☐ Warmed — NS#4 —— 500 #6 PRBC#1 —— 2L NS } NS 5.3L
18G ☐ Warmed — NS#3 —— P —— 400

LOSSES EST BLOOD LOSS 100 ... 300
URINE - 700

PHYS STATUS: 1 2 (3) 4 5 (E)
BODY WEIGHT: 70 (KG) LB
HEMATOCRIT:
INITIAL DATA: BP- 75/134 HR- 115
EQUIP CHECK OK?- (Y) N
PATIENT RECHECK OK for PROCEDURE? JM TIME- 2030

TIME ➔ 2045 2100 . 30 . 2200 . 30 . 2300 . 30

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-⊘

Lab values on grid: pH 7.39 / 7.36; Na 143 / NS; PCO_2 29.1 / 27.4; K 3.7 / 3.7; PaO_2 487 / 473; lac 1.04 / 1.00; BE -7 / -10; Hct 30 / 26; SaO_2 100 / 100; MAPs 80-90s

VENTIL

VT - ml	800	800	810	810	810	820	810	830	810	810	810	800
f - breaths/min	14	11	11	11	11	11	11	11	10	10	7	10
Peak inf pres / PEEP	—	19	19	19	21	21	21	21	21	21	21	22
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	—	—	30	28	23	22	22	22	23	28	28	—
BP/oth	FIO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	1.0
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site							Nasal 36	36.9	36.9	36.8	36.8	—
	N-M Block (T/4)		4/4			1/4		0/4		0/4	4/4	0/4	—
	BS	+	+										
Warming blkt	x1 woolblanket ——>												
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS / Position: ① ② (R) LD ③ turned 90° ... ④ ... ⑤ ⑥

REMARKS *Code drugs with numbers, events with letters*
① Pre-op assessment, Room monitors, O2 cricoid press, Induced, eyelids taped closed. See airway management. OG & soft bite block placed.
② (R) radial A-line x1 attempt sutured
③ Trendelenburg (R) IJ
④ PRBC #1
[redacted]
Dr Lyons @ BS.
⑤ To CT; head seen by Surgeon — evacuated
⑥ To ICU — Report
SIMV 10 800mL T, 100% +5
P = Phenylephrine 100mcg IV TIE

RECOVERY AT 2345
PACU (ICU) 1 (Specify)
OTHER
CONDITION: Stable
RESP- 10 SpO2- 100
BP- 124/70 HR- 88

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	2040	2050	2350
	Ready	**Begin**	**End**
PROC	2115	2150	2320

PROCEDURES and CPT Codes: (L) temp. craniotomy for EDH

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* DL x1 MAC 4 grade 1 view 8.0 OETT styletted, ⊕BBS ⊕ust ETCO2

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted]
b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHETIST: [redacted] CRNA/MAJ

PROCEDURE LOCATION: T

DATE: 18 Sept 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

MEDCOM - 19472

ACLU-RDI 1652 p.32

DOD-033046

ANESTHESIA PLAN OF CARE PrePROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 7 **DAYS MOS YRS** **Sex** (✓) **MALE** ( ) **FEMALE**

PROPOSED PROCEDURE: MUA - fell off vehicle
SURGICAL SERVICE:
NPO SINCE: ?

ASA Physical State 1 2 3 4 5 E
WT: 20 KG/LB HT: ____ IN.
ALLERGIES: ?

HABITS:
TOBACCO: ?
ETOH: ?
DRUGS:

CURRENT MEDICATIONS: Ø
( ) = ordered as premed

(✓) Ign Anafl
(✓) Ranitidine 50mg IV
( ) 3mg Ativan IV
(✓) Phenergan 12.5mg
( )
( )

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ____/____
U/A:
OTHER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	?
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	?
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	?
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	?
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

?

PHYSICAL EXAMINATION
BP 94/56 HR 114 R 24 T ___
Pain Scale 0-10 ____
HEENT - Teeth
Trachea
TMJ/Neck
Oropharnyx
Nares
CHEST: Course (=) B
CARDIAC: RRR tachycardic
EXTREMITIES:
IV Access:
Ulnar Filling:
BACK:
OTHER:

NPO Since ____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (✓) General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

b(6)-2

The pa[redacted] to understand and agrees. Questions answered.
Signe[redacted] CRNA/MD Date: 18 Sept 03 Time: 2045 Hrs

PO[redacted]THESIA EVALUATION [redacted] (NON ASU)
{ } [redacted]APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. **ANESTHESIA.** Patient does not respond to painful stimulation.

Patient Identification: (Ward) ____

CIV #[redacted] b(6)-4

518–124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*
_____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 18 Sep 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE [redacted]

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 18 Sep 03

TIME VERIFIED 1920

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO. [redacted]

DONOR
ABO O
Rh Neg

RECIPIENT
ABO O
Rh Neg

TEST INTERPRETATION
ANTIBODY SCREEN: NA
CROSSMATCH: Compat

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 18 Sep 03

REMARKS: exp 27 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 2232 [redacted] ON *(Date)* 18 Sep 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* [redacted] CRNA/MAJ

2 [redacted] ER *(Signature)* [redacted] b(6)-2

TEMP. [redacted] PULSE 84 BP 85/58

DATE OF TRANSFUSION 18 Sept 03 TIME STARTED 2240

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, [redacted] rade; rank; rate; hospital or medical facility)

[redacted] b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN 300 ML

TIME/DATE COMPLETED/INTERRUPTED 9-18-03 2300

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE 36.8 PULSE 92 BLOOD PRESSURE 102/63

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON [redacted] CRNA

SEX M WARD EMA

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 19474

Medical Record Copy

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Head CT		M	7[redacted]4	CMT	
	FILM NO.			PREGNANT ☐ YES ☐ NO	
	REQUESTED BY (Print) Gowen			TELEPHONE/PAGE NO.	
	SIGNATURE OF REQUESTOR [redacted]			DATE REQUESTED 18 Sep 93	

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

Head Injury

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

1) Small Mod (L) parietal epidural fx 1 cm thick
acute/a

2) (L) parietal-occipital skull fx - drop 3mm extends into oblique (L) temporal fx.

3) (L) parietal SAH and intercerebral falx.

[redacted]
b(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

[redacted] b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 19475 TATION RT

2 — PHYSICIAN

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

PACER DISPLAY ON
RESP
SpO2
MEDCOM - 19476

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/18/03 TIME OF ORDER 1945 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICU
2. Dx: Basilar Skull Fx/Concussion Moderate
3. HOB @ 30°
4. Restraints due to Combativeness
5. IV D5 0.9 NS w/ 20 KCL @ 100 cc/hr
6. PRN: Dilantin 100 mg q 8°. Ativan 1-2 mg q 4-6° prn agitation
7. Foley to gravity
8. Bed rest
9. CBC, PT/PTT/Chem-7.
10. NPO after midnight
11. Ortho c-collar

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/18/03 TIME OF ORDER HOURS

12. Admit to ICU
13. Dx: S/P Crash of EDH
14. VSS
15. HOB Flat D/C'd b(6)-2
16. NPO
17. ~~PRN~~ Dilantin 100mg IV q8°
18. IV D5 0.9NS w/20 KCL @ 100 cc/hr

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

19. MSO4 1-2 mg IV prn pain. HOURS
20. Foley Gravity
21. Versed/Fentanyl [redacted] on Sedation
22. Ventilation: [redacted] mode AC

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 19477

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/18/03 TIME OF ORDER 23:40 HOURS

LIST TIME ORDER NOTED AND SIGN

1. HOB @ 30°
2. versed 4mg/hr IV drip prn sedation
3. Fentanyl 100 mcg/hr IV drip prn sedation
4. Dilantin 100 mg IVPB q8°
5. CBC, PT, PTT, Chem 7 qam
6. ABG discont - 24 hrs ago
7. Rocef 1gm IVPB q8°

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT: Ian 1 | ROOM NO.: 1 | BED NO.:

DATE OF ORDER 9/19/03 TIME

1. ↑ RR to 12

b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 19 Sep TIME OF ORDER 1720 HOURS

V.O ABG in 30 min

Dr [redacted] b(6)-2

Taken by [redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/19/03 TIME OF ORDER HOURS

1. D/C IV
2. Advance Clears

[redacted]

b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 19478

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

Noted 21SEP03 [redacted] AN

DATE OF ORDER: 9/21/03 — TIME OF ORDER: 1300 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Tx to ICW
2. Dx: S/P (L) Parietal Skull Fracture
3. w/Epidural hematoma evacuation
4. Stable
5. Vitals c 4° w/ neuro √'s
6. NKDA
7. Advance Clears diet as tolerated

PATIENT IDENTIFICATION: b(6)-4 [redacted] b(6)-2

DATE OF ORDER — TIME OF ORDER — HOURS

8. Act: sit-up in Chair w/ assistance only.
9. IVF D5 0.9NS w/20 KCl @ [illegible]
10. Foley D/C.
11. ~~CBC~~ chem7 qod

MED: Ancef 1gm IVPB x 8° x 2 doses.

Dilantin 300mg po qhs qd

12. Ambulate w/ assista[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] b(6)-2 HOURS

b(6)-2

24° [redacted] AN 22Sep03 0445

24° Chart √ [redacted] 9[illegible] 22Sept03 0005 [redacted] [illegible]/AN 22Sep03 0500

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: [redacted] b(6)-4

DATE OF ORDER: 23SEP03 — TIME OF ORDER: 1154 HOURS

1. T3 1-2 po q 4° prn Pain (severe)
2. Tylenol 650 [illegible] q 4° prn (mild)

[redacted] 4757 b(6)-2

Noted 23Sep03 1200 [redacted] b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO. b(6)-2

~~24° Chart√~~ [redacted] 9[illegible] 24 Sept 0030 24° [redacted] 24Sep03 0310

b(6)-2

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

☆ U.S. GC MEDCOM - 19479 -710

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/24 TIME OF ORDER ____ HOURS

D/C Dilantin

D/C KCL. b(6)-2

LIST TIME ORDER NOTED AND SIGN

Noted 24Sep03 0915 MAJ/AN [redacted] b(6)-2

PATIENT IDENTIFICATION b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/24/03 TIME OF ORDER 0930 HOURS

Order Clarification: Advance diet as tolerated

VO Dr [redacted] MAJ/AN

Noted 24Sep03 0930 [redacted] MAJ/AN

24a chart [redacted] 9Illume 25 Sept 03 0210 [redacted] 25Sep0348C

PATIENT IDENTIFICATION b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/30/03 TIME OF ORDER 0809 HOURS

① D/C, to RTD

② Remove Sutures/Staples [redacted] b(6)-2

Done Noted 9/30/03 0815 [redacted] MAJ/AN b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER ____ HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

☆ U.S. GOVE MEDCOM - 19480

b(6)-2 A11

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ___ Yr. 2003

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME
19Sep	[redacted]	VSI
19Sep	[redacted]	NPO } DC 20Sep03
19Sep	[redacted]	foley to gravity
19Sep	[redacted]	Vent: TV800, RR-10, FiO2-40%, mode=AC
19Sep	[redacted]	HOB 30°
19Sep	[redacted]	CBC, CH7, PT/PTT qAM ABG qAM
19Sep	[redacted]	↑RR to 12
20Sep	[redacted]	Advance clear diet

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

HR	DATE COMPLETED 18 19 20 21 22
06	[redacted]
18	[redacted]
06	[redacted]
18	[redacted] DC'd 20Sep03 2120
06	[redacted]
18	[redacted]
06	[redacted]
18	[redacted] DC'd 20Sep03 2120
06	[redacted]
18	
06	[redacted]
18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p Burn & EDH

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION: [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15	
E	16	17	18	19	20	21	22	23	
N	24	01	02	03	04	05	06	07	

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 19481

b(4)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19Sep	[redacted]	Admit to ICU				
19Sep	[redacted]	BPG now				
19SEP	[redacted]	ABG q30 mins	19Sep	1745	1750	[redacted]
20SEP	[redacted]	D/C IJ access	20SEP	1600	1600	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		
-----	-----		

USAPA V1.00

b(6)-2 A11

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 9 Yr. 2003

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27	28	29	30	1	2	3
21SEP03	[redacted]	Vitals q 4° c NC	D	/	[redacted]											
			E													
			N													
21SEP03	[redacted]	Advance diets as tolerated	D	/	[redacted]											
			E													
			N													
21SEP03	[redacted]	Act: Sit-up in chair c assistance only	D	/	[redacted]											
			E													
			N													
~~21SEP03~~	[redacted]	~~IV: D5 0.9NS c 20KCl @ 100 cc/hr~~	D													
			T													
21SEP03	[redacted]	Chem 7 qod	04	/	WD	/	( )	/	WD	/	WD	/		/		/
21SEP03	[redacted]	Ambulate c assistance	D	/	[redacted]											
			E													
			N													
24Sep	[redacted]	Advance Diet as tolerated Regular	08	/	/	/	[redacted]									
			12	/	/	/										
			18	/	/	/										

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
S/P @ Parietal skull Fx c Epidural hematoma Evacuation

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: _____

PATIENT IDENTIFICATION:
C [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

b(4)-2 A-1

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo 04 Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21SEP03	[redacted]	Transfer to ICW - stable	21SEP	Done		[redacted]
21SEP03	[redacted]	Foley DC.	21SEP	Done		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ___ Yr. ___

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21
19 Sep	[redacted]	Dilantin 100 mg IV	03	/	[redacted]		
		q8°	11	/			
			19	/			
19 Sep	[redacted]	DS, 9NSE 20K @	06	/	[redacted]		
		100 cc/hr	18	[redacted]			
19 Sep	[redacted]	Versed 4mg/hr W drip	06	/	[redacted]		
		prn sedation	18	[redacted]			
19 Sep	[redacted]	Fentanyl 100 mcg/hr	06	/	[redacted]		
		W gtt prn sedation	18	[redacted]			
19 Sep	[redacted]	Ancef 1gm IVPB q 8°	06	/	[redacted]		
			14	/			
			22	/			

DC'd 20Sep03 2120 MT2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p Evac of EDH

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO. ___

PATIENT IDENTIFICATION: [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14	
E	15	16	17	18	19	20	21	22	
N	23	24	01	02	03	04	05	06	

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. _____ Yr. _____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED														
19Sep	[redacted]	MSO4 1-2mg IV	D														
- - - - -	- - - - -	prn pain	T														
- - - - -	- - - - -	q4-6	I														
- - - - -	- - - - -																
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USAPA V1.00

b(6)-2 A-1

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 9 Yr 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21 22 23 24 25 26 27
24SEP03	[redacted]	IV: D5 0.9NS c 20Kcl @ 100 cc/hr.	D	[redacted]
			E	[redacted]
			N	[redacted] Ndc 24Sep03
21SEP03	[redacted]	Ancef 1gm IVPB x 8° x 2 doses	06	[redacted]
			22	[redacted]
21SEP03	[redacted]	Dilantin 300mg PO qhs q.d.	20	[redacted] dcd 24Sep03
24Sep03	[redacted]	IV: D5 0.9NS @100/hr (HL)	D	/ / / 0 [redacted]
			E	/ / / [redacted]
			N	/ / / [redacted] DC

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: s/p (L) Parietal skull Fx c Epidural hematoma Evacuation

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO. _____

PATIENT IDENTIFICATION:

4B C [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 9 03			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	-----					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
23Sep 26Sep	[redacted]	Tylenol #3 1-2 po q 4° prn severe pain	23Sep 0935 1600 26Sep 0600 1830
23Sep	[redacted]	Tylenol 650mg po q 4° prn mild pain	23Sep 0630 26Sep 0745 27Sep 1600 27Sep 2000 28Sep 0730
		b(6)-2 Att	

D/C 29 Sep 03

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*: QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0600	INITIAL [redacted]	b(6)-2	INITIALS		INITIALS
NEURO		PUPILS	Reactive 3mm Bilat					
		SENSORIUM	Alert oriented					
			Moves all ext					
RESPIRATORY		RESPIRATORY PATTERN	Reg Equal chest exp					
		BREATH SOUNDS	bilateral ~~bases~~ Breath Sounds Clear					
		SECRETIONS	Ø					
			Sat 97-100%.					
			on Room Air.					
SKIN		COLOR	~~Abnormal~~ Yellow Normal					
		INTEGRITY	Pink, intact except for Surgical					
			Head incision and abrasions Sutured					
IV SITE		LOCATION	(L) AC intact					
		CONDITION	(R) forearm intact					
			D5 NS TKE 20 kcl @ 100cc/h					
GASTRO		ABDOMEN	Soft Nontender					
		BOWEL SOUNDS	BS(+)					
GU		URINE:	Foley					
		COLOR/CLARITY	clear yellow/Red					
CARDIOVASCULAR		CARDIAC RHYTHM	SR. Hr 70-80's					
			BP 110/64					
			Ø edema RLE					
			Ø chest pain.					

LEGEND

Cr - Creatinine; F_iO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

b(6)-2

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU I

DATE: 21 Sep 03

(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

CIV [redacted] b(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DATE 21 Sep 03 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	8	9	10	11	12	13	14
BP Arterial Line									
BP Cuff	102/64	114/58	104/60	106/61	105/65	108/65	98/65	112/72	91/54
Temperature	98.7			99.4			99.7		
Pulse	66	79	90	78	106	75	76	96	76
Respiratory Rate	24	21	22	22	22	24	18	20	25
Sao2	98	97	97	97	97	66	98	95	96
	RA	RA	RA	RA	RA	RA	RA	RA	RA

INTAKE

TIME									8° T									8° T
D5NS+KCl20K	100	100	100	100	100	100	100	100	100									
IVPB	50					100			150									
TOTALS																		

OUTPUT

		HOUR / TOTAL																	
URINE			350	325						2200									
		sp gr																	
		S/A																	
NG		OUTPUT																	
		pH																	
		GUIAC																	
EMESIS								100											
STOOL																			
DRAINS										Jackson DC									
TOTALS																			

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

INTAKE

8° T

OUTPUT

RESPIRATORY

TIME										
MODE										
F_iO_2										
TV										
RATE										
PEEP										
ARTERIAL A: pH										
ARTERIAL A: PCO_2										
ARTERIAL A: pO_2										
ARTERIAL B: HCO_3										
ARTERIAL B: SAT										
ARTERIAL G: BASE										

LABORATORY DATA

TIME										
GLUCOSE										
Na/K										
Cl/CO_2										
BUN/Cr										
WBC/PLATELET										
Hct/Hgb										

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN

TIME						

SUCTION

TIME						

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE [redacted] INITIALS

b(6)-2

MEDCOM - 19491

NEUROLOGICAL ASSESSMENT

COMA SCALE

			HOURS: 09
EYES OPEN	SPONTANEOUSLY	4	4
	TO SPEECH	3	
	TO PAIN	2	
	NO EYE OPENING	1	
BEST VERBAL RESPONSE	ORIENTED	5	unable to assess, pt does not speak Arabic or English
	CONFUSED	4	
	VERBALIZES	3	
	VOCALIZES	2	
	NO VOCALIZATION	1	
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	6
	LOCALIZES PAIN	5	
	FLEXION WITHDRAWAL	4	
	ABNORMAL FLEXION	3	
	EXTENSION TO PAIN	2	
	NO MOTOR RESPONSE	1	

LEGEND: C Closed by swelling; T Trach/Endo; S Slurring; D Dysphasia; R Receptive; E Expressive

LIMB MOVEMENT

ARMS	NORMAL POWER	6
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	
LEGS	NORMAL POWER	6
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	

R Right; L Left. Record separately if there is a difference between the two sides.

PUPILS

RIGHT	SIZE	3
	REACTION	++
LEFT	SIZE	3
	REACTION	++

++ Brisk; + Slow; - No Response

PUPIL SCALE: 2 3 4 5 6 7 mm

ICP

CEREBRAL PERFUSION PRESSURE

+ Intact; - Abnormal

VASCULAR ASSESSMENT

HOURS	
	R / L
	R / L
	R / L
	R / L
	R / L

LEGEND: ++ Normal; + Weak; - Absent; D Doppler; R Right; L Left

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

b(6)-2

		SHIFT ASSESSMENT	
		TIME: 0610 INITIALS: [redacted]	TIME: 1900. INITIALS: [redacted]
NEURO	PUPILS	PERLA 3mm Brisk	PERRLA 3mm. Eyes are disconjugate.
	SENSORIUM	Moves extremities to pain and spontaneously	Pt is responsive to tactile stimuli.
	EXTREMITY MOVEMENT	Does not follow instructions/questions	Pt moves all 4 extremities in a non
	SEDATION	in english. Fent 50 Versed drip 2mg	purposeful manner. Pt is sedated
	PAIN CONTROL	MSO4 [redacted]	c 4mg/hr versed & 50mcg/hr
			fentanyl.
RESP	RESPIRATORY PATTERN	Vented. Intubated #8 ETT 24cm @ lip	Intubated. #8 UETT, @ 24cm @ lip.
	BREATH SOUNDS	Bilateral Breath Sounds clear Equal	vented AC 12, 40%, 800, 5. Peak pressure
	SECRETIONS	chest expansion. Suctioning of secretions	20-22cm H2O when pt not agitated. Breath
	O2 SOURCE/FLOW/SAO2	Blood tinge secretions draining from mouth	Sounds clear bilat. SpO2 100%. Non
	VENTILATOR SETTINGS	TV 800 Rate 12 FIO2 40% Resp AC.	overbreathing vent. Equal Chest expansion
CV	CARDIAC RHYTHM	SR HR 80's BP 108/60's S1 S2	HR 80-90's. S1-S2. NSR.
	CAPILLARY REFILL	<3 Sec	(+)1 (B) UE radial pulses, (+)2 (B) pedal
	PULSES	All peripheral pulses (+)	Edema noted to (R) parietal area.
	EDEMA	(+) edema (R) Hand	Cap refill <3 sec.
		Cordis to (R) IJ	
		A line to (R) Radial.	
GI	ABDOMEN	Abdomen Non distended Soft to touch.	Abd Soft. BBS noted. OGT to LIS
	BOWEL SOUNDS	Hypoactive.	c green liquid drng.
	BOWEL MOVEMENT	Ø	
	NGT/OGT	OGT to intermittent suction	
	TUBE FEEDINGS	Ø	
	DRAINS	Ø	
GU	VOIDING	Foley	Foley to gravity drng clear light
	COLOR/CLARITY	Clear Yellow	yellow urine.
SKIN	COLOR	Normal	large incision to (L) parietal area. Suture
	INTEGRITY	Intact. except for Head Surgical	intact.
		wound c Staples (intact)	
ACCESS	#1 TYPE/LOCATION/SIZE	Cordis (R) IJ	(R) IJ cordis. D5 .9NS + 20K @ 100cc/hr
	DRESSING CONDITION	Intact	vs/sed @ 4CC/hr, and fentanyl @
	IV FLUID/RATE	D5NI + 20 KCl at 100cc/hr Fentanyl/Versed drip 2mg	50c/hr infusing. Inserted 9/19/03
	#2 TYPE/LOCATION/SIZE	Left AC #18G (R) Forearm #14G	(R) FA 14G and (L) AC 18G PIV
	DRESSING CONDITION	Intact Intact	Saline locked. No drng. Flushes
	IV FLUIDS/RATE	(HL) (HL)	easily.

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU #1, [redacted] (b)(2)-2

DATE: 19Sep03

PATIENT IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

NAME: b(4)-4 RANK: AGE:

UNIT: #[redacted] GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 19493

USAPPC V2.00

ICU1

Patients Name: b(2)/b(6) # [redacted]

Date: 19 Sep 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	108/61	108/63	113/58	out																						
NBP		95/61	97/61	96/60	89/55	96/62	97/60	93/63	95/62	94/61	93/65	96/63		99/61	103/65	100/62		100/62	103/60	110/72	106/67	109/69	105/66	105/65	104/61	
TEMP	99.1				98.6				98.1					99.6		99.1									98.3	
HR	98	97	95	96	83	83	99	95	92	94	98	91		86	90	82		82	85	86	85	88	77	81	78	
RR	10	10	10	15	10	10	10	10	10	10	10	10		12	12	13		13	13	13	12	12	12	12	12	
SaO2	100%	100	100	100	100	100	100	100	100	100	100	100		100	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%	
FiO2	40%	40	40	40	40	40	40	40	40	40	40	40		40	40%	40%		40%	40%	40%	40%	40%	40%	40%	40%	
Source	SIMV/PS	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC		AC	AC	AC		AC	AC	AC	A/C	AC	AC	AC	AC	
MAP		76	76	74	68	75	73	74	75	74	77	75		75	80	77		71		66	78	77		79	77	

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
IVF	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	12
IVPB	50*						100		50				200				100	50					50			7
NGT																										
Versed	2	2	2	2	4	4	4	4	4	4	4	4	40	4	4	4	4	4	4	4	4	4	4	4	4	48
fentanyl	5	5	5	5	8	6	6	6	5	5	5	5	66	5	5	5	5	5	5	5	5	5	5	5	5	6
Total	157/157	107/264	107/371	107/478	112/590	110/700	210/910	110/1020	159/1179	109/1288	109/1397	109/1506		109/1615												

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	40	40	200	160	160	90	60	60	100	100	120	130		200	240/115	100/140		350/2160		270/2430	350/2780	115/2895	10/2905	284/3189	78/3360	3360
NGT																										
STOOL																										
DRAIN JP							25							25							25				20	95
Total	40/40	40/80	200/280	160/440	160/600	90/690	85/775	60/835	100/935	100/1035	120/1155	130/1285		225/1510												

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*
INTENSIVE CARE NURSING FLOW SHEET	QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0015. Initals: [redacted] b(6)-2	Time: Initals:
NEURO	Pupils	2mm PERRLA. Pt is sedated and	
	Sensorium	paralyzed from OR. Pt not moving	
	LOC / GCS	extremities. S/p epidural hematoma.	
CARDIAC	Cardiac Rhythm	S1-S2. Sinus rhythm. Rate 90's.	
	PRI: / QRS:	+2 (B) pedal pulses, (T) 1 (E) radial	
	Pulse Strength	pulse, (D) 2 (C) radial pulse. Cap refill	
	Cap Refil / JVD	<3sec. Ø edema noted.	
	Edema		
	Chest Pain		
RESP	Respiratory Pattern	Intubated #8, 24cm @ lip. SIMV	
	Breath Sounds	10, TV 800, PEEP 5, FiO2 100% initially then	
	Secretions	↓ to 40% following ABG. SpO2 100%. Breath	
	Cough	sounds clear bilat. Equal chest expansion.	
		Peak pressures 20-22 cmH2O.	
SKIN	Color	warm & dry. Staples to (L) parietal lobe	
	Integrity	intact. Bloody drng noted to gauze dsg	
	Backside	JP x 1 to (L) parietal lobe to bulb suction	
		c bloody drng.	
IV	Access Devices	(R) IJ cordis c fentanyl - 50mcg/hr, versed	
	Location	4mg/hr, and DS 9NS @ 200cc/hr @ 100. (B) FA	
	Condition	14G PIV and (C) AC PIV saline locked. (R) radial	
		A-line. Zeroed & leveled. Good square wave.	
GI	Abdomen	NA correlating c NIBP.	
	Bowel Sounds	Abd soft. +BS noted. OG tube to LIS.	
	Stoma/Ostomy	Placement verified via air bolus. to (D) UA. Small	
		amount clear brown drng noted.	
GU	Device	Foley to gravity drng clear light	
	Color / Clarity	yellow urine. >1cc/kg/hr.	

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
	ICU #1, [redacted] b(2)-2	18Sep03.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

NAME: RANK: AGE:

UNIT: # [redacted] b(6)-4 GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

ICU3

Patients Name: [redacted] blw-4 Date: 18 Sep 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																				125/71	113/58	104/59	107/60	105/62	104/61	
NBP																				98	91/55	85/57				
TEMP																				99	98.2	98.7			99.1	
HR																				89	97	99	96	98	94	
RR																				10	10	14	10	10	10	
SaO2																				100	100	100%	100%	100%	100%	
FiO2																				100	40	40%	40%	40%	40%	
Source																				V	Vent	Vent	Vent	Vent.	Vent	
M[redacted]																				87	75	76	71	77		
																				~~87~~						

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	To
IVF																				7500	100	100	100	100	100	80
IVPB																							100			10
NGT																					~~50~~					
Versed																					4	—	—	2	2	8
Fent																					5	—	—	5	5	15
PRBCs																				350 gr						
F[redacted]																										
al																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
[redacted]NE																			40 gr	650	200+	230	75	80	85	2126
NGT																					50					
STOOL																										
DRAIN JP																				65	~~60~~ 30		30		15	140
EBL																				500						500
Total																										

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

b(4)-2

INITIAL SHIFT ASSESSMENT

		Time: 0615 Initals: [redacted]	Time: 1800 Initals: [redacted]
NEURO	Pupils	PERRLA 2mm Brisk	PERRL Brisk
	Sensorium	Moves extremities to pain and spontaneously. Does not follow commands given in English	Moves all extremities
	LOC / GCS		
CARDIAC	Cardiac Rhythm	SR Hr 80's	S, S, normal intensity/murmurs noted. Pulses palpable x 4
	PRI: / QRS:	.12	
	Pulse Strength	all Peripheral pulses +	
	Cap Refil / JVD	<3 - JVD	
	Edema	- edema.	
	Chest Pain	unable to ascertain	
RESP	Respiratory Pattern	12 NOT Labored Vented	LSCR not labored = equal rise/fall of chest. Lung sounds CTA bilat
	Breath Sounds	Clear & bilaterally equal chest exp	
	Secretions	min	
	Cough	+ gag.	
SKIN	Color	Normal	NSFR = ecchymosis to (L) side of head.
	Integrity	Intact except for surgical wound in head. Bruised backside	
	Backside		
IV	Access Devices	Cordis to (R) CCJ - intact.	PIV = D5NS @ 20 mg/hr
	Location	(HC) to (L) Arm Intact	
	Condition	(HC) to (R) forearm intact.	
GI	Abdomen	Nondistended Soft & round	(-) TRD (+) BS x 4 quads
	Bowel Sounds	BS hyperactive	
	Stoma/Ostomy	∅	
GU	Device	Foley	foley & patency DS clear tyellow urine.
	Color / Clarity	pale clear	

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] b(4)-2 LT.

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU #1, [redacted]

DATE 20 Sep 03.

Typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

NAME: [redacted] RANK: AGE:

UNIT: [redacted] b(6)-4 GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

ICU3

Patients Name: #[redacted] 61(5

Date: 20 SEP 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	106/68	112/79	105/60	108/65	109/65	109/62	116/79	112/67	108/65	105/70	118/82	112/67		123/67	104/64	108/60	109/60	104/60	111/60	99/60	103/54	99/58	116/63	114/56		
TEMP	98.3			99	99				98.9						99.7		99.3									
HR	79	83	81	84	79	99	92	87	87	94	93	91		89	92	112	111	98	76	85	80	103	67	67	84	
RR	12	12	12	12	12	14	15	20	21	17	14	20		10	21	23	29	20	18	17	22	14	19	19	21	
SaO2	100%	100	100	100	100	100	100	100	100	100	100	98		97	99	99	97	97%	98	98%	99%	100%	99%	99%	98%	
FiO2	40%	40	40	40	40	40	6L	6L	6L	6L	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
Source	AC	AC	AC	AC	AC	AC	NKM	NKM	NKM	NKM																
MAP	81	90	77	78	79	82	90	84	82	81	67	84														

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
IVF	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100	100	
IVPB	50					100			50									50					100			
NGT																										
Versed	4	4	2	2	2	2	Dc'd																			
Fent	5	5	5	5	3	0																				
PO Subtotal	159	109	107	107	105	202	100	100	150	100	100	100														
al	159	268	375	482	587	789	889	989	1089	1189	1289	1389	(1389)													

PUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
UPE	310	400	280	300	120	250	300	350	250	250	350	300		350	100	200	80	260	400	200	200	120	120	280	140	
NG.																										
STOOL																										
DRAIN																										
SubTotal	310	400	280	300	120	250	300	350	250	250	350	300		350												
TOTAL	310	710	960	1260	1380	1630	1930	2280	2530	2750	3100	3400	(3380)	3850												

MEDCOM - 19498

DOD-033072

ACLU-RDI 1652 p.58

b(2)-2

ICU 1
burn unit

[redacted] Iranian
8.0 ETT 24@ teeth

[redacted] **VENTILATOR FLOW SHEET**

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
19 Sep	0001	Simv	10	800	100	5	22	10	92	100%	124/74	7.29	36.4	481	-7	18	100	NSK - A's to A/C, 402
	0130	A/C	10	800	40	5	24	10	97	100	111/62							NSK
	0330	A/C	10	800	40	5	24	10	98	100	108/65							NSK
	0605	A/C	10	800	40	5	19	10	97	100	105/60	7.31	39.5	188	-6	24	100	NSK
	0800	A/C	10	800	40	5	28	30	114	100	125/72							BR
	1000	A/C	10	800	40	5	20	10	83	100	85/57							BR
	1200	A/C	10	800	40	5	22	10	88	100	91/60							BR
	1400	A/C	10	800	40	5	28	10	95	100	95/62							BR
	1600	A/C	10	800	40	5	24	10	89	100	98/61							RAR
	1800	A/C	12	800	40	5	23	12	93	100	113/70							KER
	2000	A/C	12	800	40	5	22	12	91	100	110/70							KER
	2200	A/C	12	800	40	5	22	12	91	100	104/62							RAR
20 Sep	0000	A/C	12	800	40	5	23	12	84	100	100/67							RAR
	0200	A/C	12	800	40	5	23	12	79	100	100/67							RAR
	0600	A/C	12	800	40	5	23	12	94	100	104/61							KER
	0800	A/C	10	800	40	5	19	10	80	100	105/62							BR
	1000	A/C	12	800	40	5	20	12	77	100	104/65							BR
	1200	Pt extubated																BR

MEDCOM - 19499

EMERGENCY CARE AND TREATMENT (Medical Record) 21st CSH OP 01

Treatment Facility: 21st CSH/EMT

BED #

ARRIVAL TIME: 1515 18 Sep 03

DAY	MONTH	YEAR
18	Sep	03

TRANSPORTATION
Ground Tactical ☐ Air Rotary ☐
Ground Ambulance ☐ Air Fixed ☐
Other ☐

ALLERGIES: NKDA

MEDICATIONS: NONE

CHIEF COMPLAINT: Head Injury

PAIN SCALE (1-10):

TETANUS:

SEX: M

AGE:

NON-URGENT ☐ URGENT ☑ EMERGENT ☐

TIME SEEN BY PROVIDER:

VITAL SIGNS

TIME	1515	1548	1612	1705	1815	
BP	119/82	117/75	105/64		105/70	
PULSE	119	105	111	58	108	
RESP	10	16	19	20	19	
TEMP			98.7 →			
%O2	95		98	98	99	

ORDERS	INIT	TIME	PAIN
CBC Chem 7	[redacted]	1519	
Type & Cross		1519	
IV NS		1520	
Td 0.5cc IM		1820	

(S) Iranian ♂ Mid 20s victim of fall from LMTV. Uncertain as to height or whether vehicle was moving.

(O) VSS; NAD; A+Ox3

Neuro: GCS = 15, CN II-XII WNL, Ø focal Ds

H: (L) superficial lac x2 to occiput (Ø suture) (+) Battle sign (L) ear

E: sclera clear. Pupils: PERRL

E: (R) TM mobile; (L) TM c̄ infection

N/T: Ø perf and medial wall lac 1mm. Hemostasis achieved. Normal dentition. Ø LAD; Ø peritonsillar exudate/edema Ø FOB

Lungs: CTA (B); Ø wheeze

CV: RRR; Ø M, G, R

Abd: Soft; Ø tender; Ø mass; Ø bruit

X-RAY: C-Spine, T-Spine, L-Spine, Pelvis clear Ø Fx

Abrasion & soft tissue injury to (L) PSIS c̄ edema and (L) shoulder

Skin: Abrasion to (L) shoulder (R) PSIS Ø RASH.

GI: (-) Guaiac

14 / 110 / 28 / 3.8 / ... / 1.2 ... 114 Ca 9.8

18.1 / 17.1 / 345

ASSESSMENT/DIAGNOSIS: R/O Concussion
Closed Head Injury
(+) Basil Skull Fx

DISPOSITION: HOME ☐ DUTY ☐
QTRS ☐ 24 ☐ 48 ☐ 72
MOD DUTY: UNTIL__________
REFERRED TO: ☐

EMERGENCY ☐ TODAY ☐ 72 HRS ☐ ROUTINE ☐

ADMITTED:__________ SERVICE: b(2)-2

CONDITION UPON RELEASE: To [redacted] for Neuro

IMPROVED ☐ UNCHANGED ☐ DETERIORATED ☐

TIME OF RELEASE: 1840

PATIENTS IDENTIFICATION:
NAME/RANK: Iranian Civilian
SSN: Iraqi # [redacted]
DOB:
UNIT: b(6)-4
LOCATION:

PROVIDER SIGNATURE: [redacted] CPT, AN ... Practice

INSTRUCTIONS TO PATIENT: Consult Surgery Service. b(6)-2

MEDCOM - 19500

ACLU-RDI 1652 p.60

DOD-033074

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN b(6)-4 Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. Iranian Civilian # [redacted]	DATE 18Sep03 / TIME 1519	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	18.1	4.8-10.8 x 10^3
RBC	5.93	4.7-6.1 x 10^9
Hgb	17.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	53.3	42-52% (M) 37-47% (F)
MCV	89.9	80-94 fl (M) 81-99 fl (F)
Plt	345	130-500 x 10^3 verified
Lymph %	8.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
SG		N/A
pH		N/A
Leu		Negative
Nit		Negative
Pro		Negative
Glu		Negative
Ket		Negative
Ubg		0.2-1.0
Bil		Negative
Bld		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
Mono		Negative
RPR		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
HIV		Negative
Micro Parasites		
Malaria		
Other		
Serum HCG		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: CBCs, Chem 7, T+C

REPORTED BY: SPC [redacted] b(6)-2	DATE: 18 Sep 03	LAB ID NO.: 661

MEDCOM - 19501

Ward/Section:	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE / TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	*RESULT*	*REF. RANGE*
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	*RESULT*	*REF. RANGE*
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	*RESULT*	*REF. RANGE*
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	*RESULT*	*REF. RANGE*
GLU	111	73-118 mg/dl
BUN	28	7-22 mg/dl
CA^{++}	9.8	8.0-10.3 mg/dl
CRE	1.2	0.6-1.2 mg/dl
NA^+	141	128-145 mmol/l
K^+	3.8	3.3-4.7 mmol/l
CL^-	100	98-108 mmol/l
tCO_2	22	18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	*RESULT*	*REF. RANGE*
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	**DATE:**	**LAB ID NO.:**

b(2)-2

[redacted] **Hospital EMT Trauma Flow Sheet**

18 Sept 03

Time of Arrival 1515
Name/Rank
Unit Civilian, Iranian
SSN:
DOB AGE: SEX M
Location of Unit:

Chief Complaint Head Injury
Time of C/C: LOC Duration
Transported by: (Air) Ground Amb Military Vehicle
Medications NONE
Allergies: NKDA

Airway ☑ Clear ☐ Obstructed Intubated ☐ Tube size
C Spine: ☐ Immobilized ☑ Cleared Time: 1622
Breathing: ☐ Normal ☑ labored ☐ shallow ☐ assisted ☐ absent ☐ trach deviation
Circulation: IV's on Arrival yes x1 (L) AC
Pulses: Upper ☑ Lower ☑ Carotid ☑
Skin: ☐ Cool ☑ Dry ☐ Diaphoretic ☐ pale ☐ flushed ☐ mottled ☐ cyanotic pink
Chest: Breath Sounds: Clear ☐ R ☐ L
Decreased ☐ R ☐ L Absent ☐ R ☐ L Wheezing ☐ R ☐ L
Rales ☐ R ☐ L Ronchi ☐ R ☐ L
Moves upper Extremities ☑ Yes ☐ No Sensation ☐ Y ☐ N
Moves Lower Extremities ☑ Yes ☐ No Sensation ☐ Y ☐ N

PROCEDURES

C Collar ☐ Backboard ☑ NG/OG ____ FR Foley ____ FR
CT ____ FR ☐ L R ☐ Rectal Tone + ____ - ____
O2 ☑ Device ____ % ____
Radiology: Time ____ XRAYS: Chest (C Spine)
AP L-spine, Lateral Skull, KUB
Labs: (CBC) (CHEM 7) Liver Panel UA T&C Units ____
OTHER
Monitor ____ EKG ____

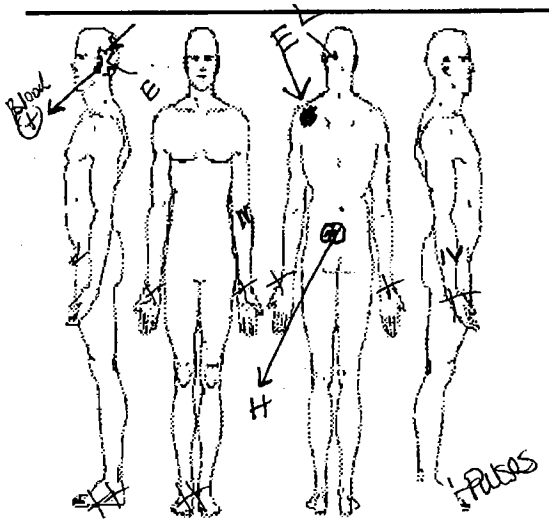
MEDICATIONS/PROCEDURES DONE IN THE FIELD

C-collar in place, spinal immobilization
IV x1 (L) AC 18G c NS running

MEDS/FLUIDS	TIME	INIT	MEDS/FLUIDS	TIME	INIT
CBCs, Chem 7	1519	[redacted]	IV NS	1520	[redacted]
Type + Cross	1519	[redacted]	IV NS	1530	[redacted]
			Total in 1.0 Liter		

Time	1515		1548								
BP	119/84	[redacted]	117/75								
Pulse	129	[redacted]	105								
Resp	10		16								
Temp											
SAO2	95										
GCS											

A - Abrasion
AP - Amputation
AV - Avulsion
B - Burn
C - Contusion
DP - Decreased Pulse
E - Ecchymosis
F - Fracture Closed
FO - Fracture Open
IV--IV Lines
GSW - Gunshot Wound
H - Hematoma
L - Laceration
LS - Sutured
P - Pain
SW - Stab Wound
S - Scar
SP - Splint
T - Tenderness
SR- Shrapnel



NOTES

Blood in left ear canal
Guiac (Neg)
L spine series
Skull series
KUB
1622 C-Spine cleared
HPI: pt arrived to EMT stp fell out of wc LMTV. GSC, +LOC on arrival. When interviewed present pt able to answer questions, aoox to identity self and place of birth; pt mildly combative; xrays completed without difficulty; VS stable throughout. c spine cleared by CPT [redacted] 1615 pt sleeping in NAD; arousable to voice will continue to mt

CON'T NOTES ON REVERSE SIDE

MEDCOM - 19503 — [redacted] WITH b(6)-2

GLASCOW COMA SCALE

1. Eye Opening:

Spontaneous	4
To Voice	3
To Pain	2
None	1

2. Verbal Response

Oriented	5
Confused	4
Inappropriate Words	3
Incomprehensible Words	2

3. Motor Response

Obeys Commands	6
Purposeful Movement	5
Withdraws (Pain)	4
Flexion (Pain)	3
Extension (Pain)	2
None	

GCS ON ARRIVAL 14

GLASCOW COMA SCALE (PEDIATRIC)

1. Eye Opening

Spontaneous	4
Speech	3
Pain	2
None	1

2. Best Verbal

Oriented, Smiles, Cries	5
Confused	4
Inapprop/inapprop cry	3
Incomprehensible/grunts	2
No response	1

3. Best Motor

Spontaneous	6
Localizes Pain	5
Withdraws to Pain	4
Decorticate (Flexion)	3
Decerebrate (Extension)	2
None	1

GCS ON ARRIVAL

NOTES (CON'T)

[redacted]

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF LOCATION (State or Country Code.)							
1	2	3	4	5	6	7	8
A	F	1	D	1	[redacted]	I	Z

3. REGISTER NUMBER						
9	10	11	12	13	14	15
[redacted]						

NAME (Last, First, Middle Initial)

4. PAY GRADE	
16	17

5. SEX
18
M

6. DATE OF BIRTH (Y Y Y Y M M D D)							
19	20	21	22	23	24	25	26

7. AGE AT ADMISSION		
27	28	29
4	0	Y

8. RACE
30
Z

9. ETHNIC BACKGROUND
31
9

RELIGION: UNK

10. LENGTH OF SERVICE		
32	33	34

ETS: NA

11. FMP	
35	36
9	9

12. SOCIAL SECURITY NUMBER								
37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION (Active Duty Only): NA

13. MARITAL STATUS
46
Z

HOUR OF ADMISSION: 1945

BRANCH / CORPS: NA b(6)-4

14. FLYING STATUS		
47	48	49

15. BENEFICIARY CATEGORY		
50	51	52
K	7	6

16. ZIP CODE OF RESIDENCE								
53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)	
62	63
I	Z

18. MOS						
64	65	66	67	68	69	70

19. TRAUMA
71

PREV. ADMISSION: YEAR [ ] ☑ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION
72
O

WARD: ICU 1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

NAME AND [redacted] TREATMENT FACILITY b(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION	
73	74
5	0

22. MTF TRANSFERRED TO					
75	76	77	78	79	80

23. DATE OF DISPOSITION (Y Y Y Y M M D D)							
81	82	83	84	85	86	87	88
2	0	0	3	0	9	3	0

24. CLINIC SVC - ADMITTING			
89	90	91	92
A	B	A	A

25. MTF TRANSFERRED FROM					
93	94	95	96	97	98

26. DATE THIS ADMISSION (Y Y Y Y M M D D)							
99	100	101	102	103	104	105	106
2	0	0	3	0	9	1	8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	
107	108

28. MTF OF INITIAL ADMISSION					
109	110	111	112	113	114

29. DATE INITIAL ADMISSION (Y Y Y Y M M D D)							
115	116	117	118	119	120	121	122

FOR LOCAL USE

(L) PARIETAL SKULL FRACTURE
EPIDURAL HEMATOMA

DX 801.20
E817.1

PX 01.24
96.71
89.61
87.03
99.04

ADMITTING OFFICER (Signature, as required): [redacted] b(6)-2 MD

SIGNATURE OF ADMITTING CLERK: [redacted] b(6)-2

DA FORM 2985, MAR 2000

MEDCOM - 19505

USAPA V1.00

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent agency is OTSG

b(6)-4

1. REGISTER NUMBER	2. NAME (Last, First, MI)		3. GRADE	ADMISSION REMARKS
[redacted]	[redacted] (EPW)			

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. [illegible]	10. PREVIOUS ADMISSION
M	15	UNK	UNK	NA	NA	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	NA	ICU 1

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ DEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NA		NA	NA		NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct From Emt	2000	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	50	SEPT 20, 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	SEPT 18 2003	b(6)-2 Dr. [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) THIGH

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]	0	0	0	3	3

SIGNATURE OF [redacted] b(6)-2 Dr. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

b(6)-2

MEDICAL RECORD	18 Sep 2003 ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

15 y/o c̄ GSW (L) proximal thigh ~1500, 5.56 mm round

Med ∅ allo ∅ PMH (-)

PHYSICAL EXAMINATION

WD ♂ alert NAD

HEENT (-)

resp (-)

ch clear ∅ (M)

abd · soft but bladder distended to umbilicus

rectal - good tone, guaiac (+)

PROGRESS *(Enter date of discharge and final diagnosis)*

extr - move all well nl motor/sens testing LLE

XLNT DP/PT pulse b/l

small medial proximal entry ~~small~~ large lat exit

compartment soft

b(6)-2

[redacted]

	DATE 18 Sep	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

MEDCOM - 19507

Discharge Note

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE 18 Sep - 20 Sep '03 — NOTES

Pt a 18 y/o male c GSW (L) proximal thigh from 5.56 mm round ~1500 18 Sep

Prev med & allo PMH neg

The wound, entry, is in proximal medial thigh with exit ~2 cm shaddle on lateral proximal thigh. There was no fracture or neurovascular injury and the patient has bounding DP and PT pulses in the left lower extremity.

He was given tetanus toxoid and has been on Abx since admission and will continue on 5 days PO cephalexin, to return if problems occur - fever, purulence, erythema, etc.

The wound margins were sharp debrided and the wound irrigated on admission.

b(6)-2 [redacted] MD LTC b(2)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO. | WARD NO.

[redacted] b(6)-4

EPW [redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18SEP03 2300	USS. AO. PERRLA. LSCTAB. HRR. ⊕ pulses to all extremities. DSG's to entry & exit wounds of ⓑ thigh CDI. Medial wound 1cm, beefy red & D/C. Exit wound to lateral ⓛ thigh 25 cm diameter, beefy red & sanguinous drainage. No c/o pain. IV AB and 100cc/hr LR. BS⊕x4. CR≤2 secs. Cont to monitor — b(6)-2 [redacted]
19Sept03 [illegible]	Received pt resting in bed, USS, A&Ox3, awake speaking ∅ c/o pain. Dsg to ⓛ thigh intact w/ old drainage noted. Tol clrs. Foley pulled SUQS 400cc clr light yellow urine. Tol diet when adv to reg. at 60% tray. IV d/c. ancef d/c. keflex started. Dsg d/c'd, c/d/i @ this time. ~~[illegible]~~ pulse LLE ⊕ toes warm & able to wiggle ∅ other remarkable assessments @ this time. Will cont to monitor pt [redacted] b(6)-2
20sep03 @0130	Assumed care @ 1800; All USS, pt A&Ox3, [illegible] throughout, ⊕ pulses x4, brisk cap Ref; ∅ c/o pain @ this time; S1S2, LSCTA ⓑ; ⊕ BSx4; all dsgs CDI ∅ drainage; pt voiding QS, clear, yellow urine, ∅ BM this shift; pt has been sleeping all shift, ∅ [illegible] communication; ∅ Δ from above assessment; restraints in place; ⊕ circulation, ∅ skin breakdown; cont to monitor — b(6)-2 [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

[redacted] b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Sept03 0900	VSS. Alert & Orient. OOB to BR for AM Care. Consumed regular diet for breakfast. Lungs clear. BS(+)4 quad. Abd soft, non-distended. PO Keflex started well. Will continue plan of care. [redacted]
~~20Sept 1445~~	~~D/C to EPW Camp escorted by MP~~ [redacted]
20Sept 1445	B&I/Cell to EPW Camp escorted by MP. [redacted] 20 Sept

b(6)-2 #11

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	2100 18 Sep Enlarged/split wounds debrided + irrigated at bedside XR - L frag at Ax in pelvis + proximal femur P- admit for ABx + labs [redacted]
19 Sep	1000 Stable, wounds clean, dry [illegible] 37 P- DC foley, po ABx, d/c 20 Sep [redacted]
20 Sep	Stable, wound clean, will d/c po cephalexin x 5 d [redacted] b(6)-2 A-11

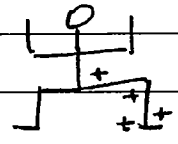
RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

PREVIOUS EDITION IS USABLE — AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Sep 03	(S) 15 y/o Iraqi ♂ EPW brought in by 3/505 with GSW to (L) leg. Pt given 1L NS IV,
All: Ø	1 Gram Ancef, 5mg morphine by 3/505 medics.
Med: Ø	SURGERY
	As above. 15 y/o ♂ c GSW (5.56 mm) (L) upper
B/P: 121/57	thigh. Only minimal to moderate blood loss
P: 63	at scene. VS as shown.
SpO2: 99	PE  pulses easily palpable, = (B).
	Through/through GSW medial → lateral thigh.
	Good ROM @ hip, knee, ankle 5/5 strength throughout.
	Minimal hematoma. Wound relatively clean.
	Plain XR femur ∼ evidence fracture.
	2° survey (-) for concurrent injuries.
A:	GSW (L) thigh.
P:	Will irrigate wound, IV Ancef b(6)-2
	Plan evac to CSH ∼ lavage.
	[redacted] CPT MC

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* — REGISTER NO. — WARD NO.

[redacted] b(6)-4

Iraqi ♂

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 Sep 03	
16:50	(S) 18 y/o ♂ received gunshot wound to (L) thigh.
P 79	pt is stable (E) entry wound (E) exit wound, no arterial bleeding
R 16	good distal pulse. pt is Alert and calm
BP 120/78	
Temp	(O) GSW (L) lateral thigh c exit wound Anterior medial ~~spot~~
Allergies &	entry wound Approx 1.5 cm pt appears in pain ∅ deformity (L) Thigh
O2 sat 98	∅ instability (L) thigh (+) good distal pulse ∅ crepitus (+) NVSI Distal
	(P) 500 1000 ml LR TKO, ↑ Full open @ 1730
	Morphine ~~4~~ 5 mg @ 18:40 IV Push
	Pressure dressing on both entry & exit wound
	Ancef ~~1g~~ 2g IV Drip c Normal Saline
1730	A: GSW (L) Thigh c Exit wound
P 78	
R 20	
BP 122/68	
Sp O2 98%	

[redacted] b(6)-2 SFC 9th MP

[redacted] 3/505 PA C

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
3/505 BAS			
SPONSOR'S NAME b(6)-4	**SSN/ID NO.**	**RELATIONSHIP TO SPONSOR**	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)		**REGISTER NO.**	**WARD NO.**

NAME: [redacted] RANK: _____

SSN: _____ DOB: 1988 AGE: 15

UNIT: _____ PHONE: _____

[redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE

~~Medical Record~~

STANDARD FORM 600 (REV. 6-97)

~~Prescribed by GSA/ICMR~~

FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

MEDCOM - 19513

b(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

UIC NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 18/09/03 | TIME: 1958

TRANSPORTATION TO FACILITY: FLA

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
15	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW (L) THIGH

CATEGORY OF TREATMENT

☐ EMERGENT
☑ URGENT
☐ NON-URGENT

TIME: 1958

INITIALS: b(6)-2 [redacted]

VITAL SIGNS

TIME	1958	2040				
BP	102/40	127/61				
PULSE	84	79				
RESP	16	20				
TEMP	99.2					
WT		0% 100%				

LAB ORDERS

☐ CBC/DIFF	☐ ABG	☐ PT/PTT	☐ BHCG/URINE/BLOOD/QUANT
☐ URINE C&S	☐ UA MSCC/CATH		☐ CHEM:
☐ BLOOD C&S X			

X-RAY ORDERS

☐ CXR PA & LAT/PORTABLE	☐ C-SPINE
☐ ACUTE ABDOMEN	☐ LS SPINE
☐ SINUS	☐ HEAD CT
☐ ANKLE R/L	

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
2000	1gm Ancef		[redacted]	2010	
2000	0.5 cc Tetnus			2010	b(6)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)*

EPW

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER
		AMD

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC			SUP 02	PH	PO2	RESULTS	∅ Trop ∅ fx's
	H/H			PCO2	SAT	OTHER		
	PLT							
PT				U/A DIP			EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU	MICRO			

PROVIDER HISTORY/PHYSICAL

S) 1530 ↑ CPW presents c GSW to (L) thigh. Minimal active bleeding (+) pulses distal to GSW. Pt states this happened around 1430-1500. ⊖ firmness in thigh. Wound has entrance & exit holes. —— DB RJ

See Surgery H&P

⊖ TOB

PMHx ⊖

PSHx ⊖

T-T (L) thigh ∅ bony trauma, N/V intact

UA 1.015 neg

A/P: Clean GSW → Ab

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

GSW (L) thigh

CODES

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

#[redacted]

b(4)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
18 Sept 03		1958	Pt arrived A/O x 3, GSW's entrance + exit (2) thigh. VSS, ↓ arterial bleed, ↓ deformity. Lt b(6)-2 [redacted]
		2010	2nd IV started, 16 Fr foley cath inserted to bladder. Blood & urine sent to lab. [redacted] b(6)-2
		2020	Pt transfered to X ray; Td 0.5 cc + Ancef 1 gm IV given. [redacted] b(6)-2
		2045	Surgeon debriding wounds, X rays done, VSS, Report given to ICU RN. Lt [redacted] BX b(6)-2

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 19516

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY				
POST- DAY				
MONTH-YEAR / DAY	18 SEP 03	19 Sept	20 Sept	
19 / HOUR	2 / 7	07	19 / 08	

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	111/54	16 / 115/55	18 / 119/70
	56	114/55	
	98.8	114/55 97.8	
HEIGHT: WEIGHT →	97.7	98.0 97.8	98 °F

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

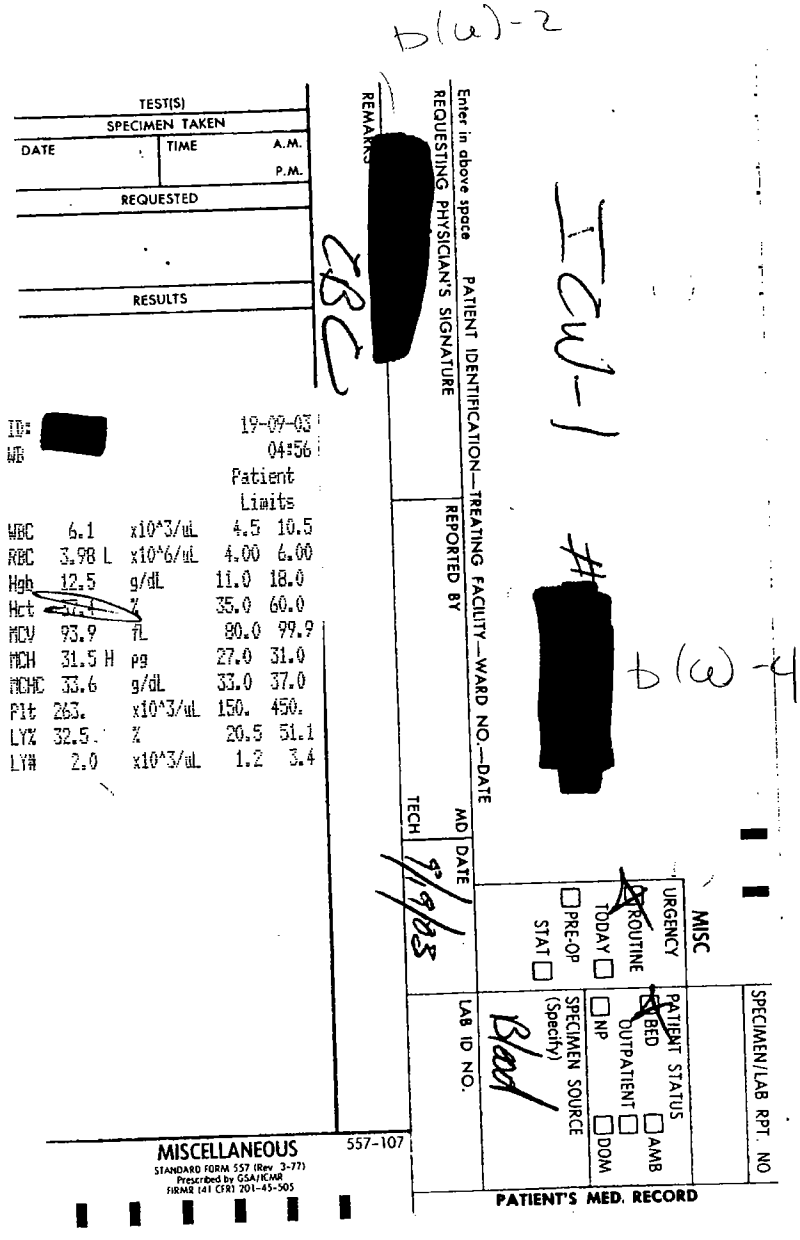
E# [redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7–95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

MEDCOM - 19517



b(6)-2

TEST(S)
SPECIMEN TAKEN
DATE
TIME A.M. P.M.
REQUESTED
RESULTS
REMARKS
CBC
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
DATE
TECH
9/9/03
MISC
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
DOM
NP
SPECIMEN SOURCE (Specify)
Blood
LAB ID NO.
SPECIMEN/LAB RPT. NO
PATIENT'S MED. RECORD

ID: [redacted]
WB
19-09-03
04:56

			Patient Limits	
WBC	6.1	x10^3/uL	4.5	10.5
RBC	3.98 L	x10^6/uL	4.00	6.00
Hgb	12.5	g/dL	11.0	18.0
Hct	37.4	%	35.0	60.0
MCV	93.9	fL	80.0	99.9
MCH	31.5 H	pg	27.0	31.0
MCHC	33.6	g/dL	33.0	37.0
Plt	263.	x10^3/uL	150.	450.
LY%	32.5	%	20.5	51.1
LY#	2.0	x10^3/uL	1.2	3.4

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR 141 (SR) 201-45-505
557-107

b(6)-1

b(6)-4

Stat

Ward/Section: EMT	REQUESTING PHYSICIAN: Dr [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW	DATE 18 Sept	TIME 2010	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC	ID: [redacted] 18-09-03	
RBC	WB 20:23	
Hgb		Patient Limits
Hct	WBC 10.8 H x10^3/uL	4.5 10.5
MCV	RBC 4.29 x10^6/uL	4.00 6.00
Plt	Hgb 13.4 g/dL	11.0 18.0
Lymph %	Hct 40.7 %	35.0 60.0
	MCV 94.9 fL	80.0 99.9
	MCH 31.2 H pg	27.0 31.0
	MCHC 32.8 L g/dL	33.0 37.0
	Plt 306. x10^3/uL	150. 450.
	LY% 16.4 #L %	20.5 51.1
	LY# 1.8 * x10^3/uL	1.2 3.4

(Hematology) Manual Differential

Segs		Mono	

Patient ID: [redacted] b(6)-2
Test Name :PT
Test Result:= 14.7 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = [redacted]
Sample Type:citrated wh. blood
Test Date :09/18/03
Test Time :08:30 PM
Card Lot :010301
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/18/03 08:34 PM

Patient ID: 795
Test Name :APTT
Test Result:= 32.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/18/03

Urinalysis

TEST	RESULT	REF. RANGE
Color	Straw	N/A
App	clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.015	N/A
Bld	Neg	Negative
pH	5.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

CSF

Cell Count			
Directigen		Negative	

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: | **DATE:** | **LAB ID NO.:**

MEDCOM - 19519

Ward/Section:	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE / TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (a 41-51 mmHg (ve
PO2		80-105 mmHg (a N/A (ven)
TCO2		23-27 mmol/L (a 24-29 mmol/L (v
HCO3		22-26 mmol/L (a 23-28 mmol/L (v
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

PICCOLO
18/09/03 20:21
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(a)-4
LIVER PANEL PLUS
DISC LOT #: 3122BA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	4.1	3.3-5.5	G/DL
ALP	201*	26-84	U/L
ALT	22	10-47	U/L
AMY	36	14-97	U/L
AST	41*	11-38	U/L
TBIL	1.0	0.2-1.6	MG/DL
GGT	6	5-65	U/L
TP	7.0	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl

PICCOLO
18/09/03 20:21
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] b(a)-2

GLU	110	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	909*	39-380	U/L
NA+	133	128-145	MMOL/L
K+	4.9*	3.3-4.7	MMOL/L
CL-	105	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	18 Sep 07	

b(a)-2

MEDCOM - 19520

CLINICAL RECORD - DOCTOR ORDERS

For use of this form, see AR 40-66; the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

[redacted]

b(6)-4

noted & transcribed 18 Sep 03 2115 LT/AN

DATE OF ORDER | TIME OF ORDER | HOURS | LIST ORDER NOTED SIG

18 Sep 2000

Admit [illegible]

Ward stable

Diet clear liq

IV LR 1000 @ 100 cc/h

Amp [illegible] IMPB q 8h

NURSING UNIT | ROOM NO | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

MS 2-4 mg IV q 1-2 h prn pain

CBC am 19 Sep

b(6)-2

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 chart [redacted] LT/AN 18 Sep 03 2115

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | LIST TIME ORDER NOTED AND SIGN

19 Sep 1000 _____ HOURS

(1) DC IVs

(2) DC Foley

(3) Keflex 500 mg po q6h

(4) Ibuprofen 400 mg po q4h prn pain

Admitted 19 Sep 0111 hrs

b(6)-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

(5) May sit in chair + ambulate

(6) Leg elev

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

299 / 05SD 20

b(6)-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

20 Sep 0700 _____ HOURS

d/c IVs pt today c Keflex

b(6)-2 [redacted]

b(6)-2 [redacted] Noted 19 Sep

NURSING UNIT | ROOM NO. | BED NO.

05 SEP 03 0730

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

_____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 19522

b(6)-2 AR

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

Mo. ___ Yr. 2003

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18 19
18Sep03	[redacted]	Diet = Clear Liquid	06 18 18-06	X [redacted] 19Sep03
18Sep03	[redacted]	NIO = Vitals Q shift	06 18 18-06	X [redacted]
19Sep03	[redacted]	May sit in chair & ambulate	06 18 18-06	[redacted]
19Sep03	[redacted]	Reg diet	06 18 18-06	[redacted]

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: GSW (L) thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION: EPW# [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 19523

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18 SEP	[redacted]	Admit ICW 1	18 SEP	[redacted]	b(6)-2	
18 SEP	[redacted]	Condition Stable	18 SEP	[redacted]		
18 SEP	[redacted]	CBC am 19 SEP	19 SEP	[redacted]	0430	[redacted]
30 SEP	[redacted]	DC pt today c Kotex				
		b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													

USAPA V1.00

b(6)-2

Medications

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ____ Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21
18Sep03	[redacted]	IV LR @ 100cc/hr	06	X [redacted]			
			12	[redacted]			
			18				
			24				
18Sep03	[redacted]	Ancef 1gm IVPB Q8	06	X [redacted]			
			14	X	/	Died 19Sep @ 1115	
			22	[redacted]	/		
19Sep03	[redacted]	Keflex 500mg po q6hr	06	/ [redacted]			
			12	/			
			18	/			
			24	/			

ALLERGIES: ☐ YES ☑ NO — PRIMARY DIAGNOSIS: GSW (L) thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO: ____

PATIENT IDENTIFICATION: # [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo	Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
		PRN Medications				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
18 Sep 03	[redacted]	MSO4 2-4mg IV q1-2 hrs prn pain	D/I
19 Sep 03		Ibuprofen 400mg po q4hr prn pain	

b(6)-2

USAPA V1.00

MEDCOM - 19526

Pt: [redacted] b(6)-4

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is ODCSOPS

PRIVACY ACT STATEMENT

AUTHORITY:	Title 10 USC Section 301; Title 5 USC Section 2951; E.O. 9397 dated November 22, 1943 *(SSN)*.
PRINCIPAL PURPOSE:	To provide commanders and law enforcement officials with means by which information may be accurately identified.
ROUTINE USES:	Your social security number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE:	Disclosure of your social security number is voluntary.

1. LOCATION	2. DATE *(YYYYMMDD)*	3. TIME	4. FILE NUMBER
	20030918		

5. LAST NAME, FIRST NAME, MIDDLE NAME	6. SSN	7. GRADE/STATUS
[redacted]	[redacted]	E-5

8. ORGANIZATION OR ADDRESS
Ace 3/505

9.

I, [redacted], WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

We were conducting searches of home for illegal weapons. During the search of one of the homes we heard gunfire. SGT [redacted] reported back that he was fired upon and returned fire. In response the entire P/t pushed to where SGT [redacted] was engaged. We found the K.d wounded about 100 meters from where SGT [redacted] said he was during the engagement.

Nothing else Follows

b(6)-2 A11

10. EXHIBIT	11. INITIALS [redacted] KING STATEMENT	PAGE 1 OF 1 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF [redacted] TAKEN AT ____ DATED ____"

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE BE INDICATED.

DA FORM 2823, DEC 1998 DA FORM 2823, JUL 72, IS OBSOLETE USAPA V1.00

MEDCOM - 19527

038

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF	2. LOCATION (State or Country Code.)
A 1 1 D 1	I Z

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted]	[redacted] b(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
	1 5 y	2	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	NA	9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	S	2000	NA b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR / NO
I Z			✓ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O	ICW 1	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted]	UNK	UNK

21. TYPE OF DISPOSITION b(2)-2	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
5 0		2 0 0 3 0 9 2 0

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
A B A A		2 0 0 3 0 9 1 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)

FOR LOCAL USE

Dx: 8900
E8912
Trauma - 1
Injury - 450
Px: 8345
8659

894.0
E891.2
86.59

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
Dr. [redacted]	[redacted] b(6)-2

DA FORM 2985, MAR 2000 MEDCOM - 19528 USAPA V1.00

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted]	EPW# [redacted] b(6)-4	EPW	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	39	—	—	—	—	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	— b(6)-4	ICU2

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K78	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	0120	AAAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION	
UNK	50	19 Oct 03	b(6)-2

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	19 Sept 03	Dr. [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to (R) flank/pelvis

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	31	31

36. Total Days All Facilites b(6)-2 [redacted]

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	[redacted]	0	0	31	31

SIGNATURE OF ATTENDING MEDICAL OFFI[redacted] MEDICAL RECORDS OFFICER

Dr [redacted]

DA FO[redacted] MEDCOM - 19529 USAPPC V1.10

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent agency is

1. REGISTER NUMBER	2. NAME	GRADE	ADMISSION REMARKS
[redacted]	EPW FF [redacted] b(6)-4	EPW	

4. SEX	5. AGE	6. RACE	7. RELIGION	SVC	9. ETS	10. PREVIOUS ADMISSION
M	40	—	—	—	—	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	—	ICU

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K78	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	0330	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK		15 oct 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	7 OCT 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: S/P GSW to abn / Bilat lower lobe pneumo

35. Total Days This Facility

ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	8	8

36. Total Days All Facilites

ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER

Dr [redacted] b(6)-2

MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDCOM - 19530

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

40 ish yo male s/p GSW to (R) flank

Presents with hypotension and combative

Meds

Ar~~fa~~n ?

Valium

PmH ?

All ?

PSH ?

TOS ?

PHYSICAL EXAMINATION

NC AT (+) EtOH on breath.

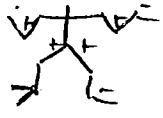
Neck NT (-) deformity

Chest CBTA

Abd - ND (+) tenderness entrance wound (R) flank.

Ext (-) d/c/e

hypotensive



FAST (+)

Back Fluctuant Area @ sacrum.

Gu WNL

Rectal Nl tone

PROGRESS *(Enter date of discharge and final diagnosis)*

A/P GSW to flank with tender abdomen and hypotension and (+) FAST -> TO OR for Ex Lap.

b(6)-2

[redacted]

	DATE	IDENTIFICATION NO.	ORGANIZATION
	19 Sep 03		

PATIENT IDENTIFICATION *(Typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10OCT03 (1655)	(cont) place's SISx complications. Will continue to monitor. b(6) [redacted]
11OCT03 0042	VSS. AO. ϕ c/o pain. Speaks some arabic appropriately. A&O to all spheres - BS⊖x4 - Steri strips remain intact to abdominal incision - ϕ S/S infection to abdomen - Resty comfortably in bed - Encouraged to use IS x2 per 10 trials and completed well. 15 ml in R base. Clear in L region. b(6)-2 [redacted] RN
11 Oct 03 0700	- Assumed care of pt. AOx3. Midline incision to abd CDI ϕ S/S of infection NO drainage noted. steri strips intact lungs clear diminished in bilat lower lobes. HRRR. IV site ⊖ PADS NS c 20 meq KCl @125 cc/hr oral flow applied. ϕ distress noted will cont to monitor b(6)-2 [redacted] RN. (1705) I concur c above assessment. [redacted] RN
11OCT03@1940	VSS, O2 sats @97% on RA, lungs CTAB but ↓ lung fields diminished ⊖, HOB ↑ 30°, steri strips to abd wound CDI, ϕ drainage noted, breakdown to sacral area - red & raw - duoderm applied CDI, Foley to gravity draining dark clear yellow urine, IV to L arm running DSNS c →

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	c 20meqKCl @ difficulty @ 125cc/. Continuing Primary IV around the clock, & other remarkable findings. Continue to monitor for acute Δ's, X2 restraints, skin integrity intact. [redacted]
12 OCT 03 0200	-Assumed care of pt. A+O X3. VSS & c/o pain or discomfort @ this time. Midline abdominal incision open to air healing secured c steri strips. Lung clear BUL diminished in bases. HRRR. Active BS foley to gravity dark amber urine. PIV D5NS c 20meq to @FA. Pt. remains afebrile IV ABX cont will cont to monitor [redacted]
12 OCT 03	@2100: VSS, A+O, O2 Sats @ 99%. RA, & SOB resp distress, LCTAB but diminished in ® lung field, HOB ↑ 30° Continuing IS exercise c difficulty, IV to Ⓛ FA infiltrated, D/C'd intact, restarted 22G to Ⓡ FA running D5NS c 20meq KCl @ 125cc/. Duoderm coming off to sacral wound (breakdown), applied new padded duoderm after cleaning area, X2 restraints, Ⓞ skin breakdown, steri strips to midline abd wound CDI, foley to gravity draining amber colored urine, & other remarkable findings, continue to monitor [redacted]

STANDARD FORM 509 (REV. 5/1999) **BACK**
USAPA V1.00

MEDCOM - 19533

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
19 Aug 2100	(L) subcl line placed - CXR in progress RA pulled back 2 cm; (R) fem sheath removed [redacted] b(a)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

#[redacted] EPW
b(a)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

b(6)-2 A11

DATE	NOTES
19 Sept 03 1130	Pt currently lying in bed sleeping. Pain medication effective. BP & naps in low 100's. Dr. [redacted] notified, will continue to monitor [redacted] pt/ssn
1230	Pt given Albumin 5%, 500 cc per physician. Labs drawn & sent to lab as ordered. [redacted] pt/ssn
1330	1 unit PRBC ~~given~~ started. V/S stable & temp of 98.5. Will continue to monitor [redacted] pt/ssn
1545	Blood complete. Pt resting comfortably in bed. Will continue to monitor [redacted] pt/ssn
1640	Pt given MSO4 4mg IVP for C/O pain. Abdominal dressings clean, dry, & intact. [redacted] CAT/ssn
2000	CBC, ABG SENT TO LAB. [redacted]
0000	CBC SENT TO LAB [redacted]
0030	PT RESTING COMFORTABLY. BED LINENS CHANGED AND PT ~~GIVEN~~. PARTIAL BATH. WILL CONTINUE TO MONITOR [redacted]
0230	PT PLACED ON O2 2L VIA NC FOR Sat [redacted] 93-96% ON RA. WILL MONITOR [redacted]
20 SEP 03 (0730hrs)	Assumed care of patient [redacted] pt receiving Δ-of-shift report. See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial shift assessment. Resting comfortably in bed & noted distress/discomfort. Will receive 2u PRBC this a.m. See "Blood Transfusion" info on separate SF 509 & vital sign hx. IVF maintenance LR @ 150cc/hr [redacted]
20 Sep 03 (1100hrs)	IVF Δ'd to D5½ & 20KCl 125cc per current Rx of LR infuses. Blood transfusion x 1 unit completed. CBC via aline @ 1200hrs (post-transfusion) Lungs & sclera throughout. SaO2: 95-96% & 2L O2 NC. Incentive x 10-20 reps q 1h performed. Productive green/tan sputum noted. Apprehensive to cough/guards abd. Abd. incisional NSW open to air per dressing removal by Dr [redacted] Incision (midline) & drainage → steri-stripped. No substantial changes otherwise from initial assessment. Will push cough/deep breath [redacted]

STANDARD FORM 509 (REV. 6/1998) BACK

USAPA V1.00

[redacted] b(6)-4

b(6)-2 A11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 Sept. 03	Pt. admitted to ICU 2 from OR S/P Ex. lap from GSW to
0505	abd. Neuro: A+O x 3. Pupils equal @ 2mm + reactive, brisk.
	Able to move extremeties x 4 equally. Resp: Resp. even, unlabored.
	lungs CTA throughout. SpO_2 100% RA. RR 12-14. CV: HR regular.
	1+ pulses (B)LE, 2+ (B)UE. BP 83/44 c MAP 59. Dr. [redacted] notified.
	Will monitor. (B)LE slightly elevated. Pre-op BP correlates. GI: Abd.
	Soft, non-tender to palpation. Hypoactive BS (R)UQ - otherwise absent.
	NGT to LIS (R)nare. Min. amt. of dark brown drainage. GU: Foley
	to gravity draining clear yellow urine. Drug tox. screen sent to lab.
	Skin: Midline abd. incision c dressing c/d/I. Smaller incision on (R)
	side of abd. c dressing c/d/I. Hemovac drain to midline incision
	c 500cc bloody drainage emptied @ 0500. Lines: (R) radial A-line.
	(R) femoral cordis. 18g HL (R)AC. 18g PIV (R)AC c LR @ 150 cc/hr
	infusing. [redacted] 1LT Ann
0515	NGT suction stopped. Multivitamin crushed + given via NGT. See
	PACU flowsheet for VS [redacted] 1LT Ann
0630	Pt received resting in bed. A+O x 3. Moves all extremities
	appropriately. See SA 4700 for initial assessment. [redacted] SGT
0730	Pt given bolus of 1000cc NS for MAPs in low 50's. Pt alert +
	oriented c no change in mental status. [redacted] CPT/RN
0915	Pt given MSO4 4mg IVP for c/o pain. Will continue to monitor [redacted] CPT/RN

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST / FIRST / MI) | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO. | WARD NO.

EPW # [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

b(6)-2 A11

DATE	NOTES
20 SEP 03 (0745hrs)	Blood transfusion 1u PRBC initiated as ordered for H/Ht 8.6 & 26.7 @ 0410hrs. Pre-transfusion
	vitals: T 98-103-31 104/65. Currently relaxed & in no noted distress. Will monitor closely
4825658	per transfusion protocol. [redacted] T/A
0750 hrs	VITAL signs: 98°ax - 106 - 32 115/73 @ s/sx adverse/anaphylactic reaction to transfusion. [redacted] CR/Ac
	Continue c transfusion
0755 hrs	VITAL signs: 98.7°ax - 106 - 30 112/71 Continues to receive transfusion w/o reaction [redacted] CR/Ac
0800 hrs	~~Assumed care of patient @ 0615hrs pr reception~~ [redacted]
0800 hrs	VITALS: 98.8°ax - 106 - 30 - 112/71; Continue c PRBC transfusion
0815 hrs	VITALS: 98.6°ax - 97 - 27 - 106/64; Continues c PRBC transfusion
0830 hrs	VITALS: 98.7°ax - 101 - 25 - 108/66; PRBC transfusion Continues
0900 hrs	VITALS: 98.7°ax - 107 - 28 - 119/74 - PRBC transfusion Contin w/o complications
0930 hrs	VITALS: 98.8°ax - 115 - 19 - 120/75 - PRBC transfusion Continues
1000 hrs	VITALS: 98.8°ax - 110 - 26 - 101/69 - PRBC transfusion continues w/o Complications
1030 hrs	VITALS: 99°ax - 114 - 25 112/72 - @ remarks D/C transfusion
1045 hrs	Transfusion Complete w/o interruption. Final VS: 98.8 - 103 - 29 104/65. (L) AC heplock flushed. Will
20 Sep	Monitor & obtain CBC @ 1200hrs [redacted] CR/Ac

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO. | WARD NO.

[redacted] EPW

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 sep	Surgery PoD#2
	No events over night
	Tm 98.6 HR 100-110 RR 16-20 BP 100-120/70's
	UO - 75-100cc/hr 6350 in / 3520 out.
	Hemorrhage ↓ ~40-50 cc/hr. Now cool aid Appearing
	Chest CBM
	cor RRR 2+PP
	Abd wound C/D/I occasional BS @ Ⓛ side
	NGT 400 x 24 hour bilious
	ext Ⓞ ck/e
	LABS 8.6 / 27 ⟨ 149 ABG 7.49/37/110/28/4.0 RA.
	127/106 / 15 ; 4.3 / 22 / 1.2
	A/P Doing well drainage ↓'d UO Adequate
	will ↓ IVF, cont NGT ↓ CBC to BID.
	[redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 19538

ACLU-RDI 1652 p.98

DOD-033112

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

b(4)-2 A11

DATE	NOTES
20 sep 03	Pt SaO_2 ↓ consistently @ 93-94%. Continues to have productive greenish sputum ↓
(1545hrs)	IS exercises. ↑ O_2 initially to 6L, ↑ SaO_2. Placed on mask c O_2 @ 10l. SaO_2
	94-95%. SaO_2 ↓ 90-91% when weaned to 6l via mask. Will monitor and attempt [redacted]
	wean in 15mn.
(1555hrs)	SaO_2 now 92-93% c O_2 @ 10l c mask. Switched to non-rebreather @ 10l. SaO_2
	unchanged. ↑ O_2 to 15l → SaO_2 95-96%. Patient RR 30-35/mn. Lungs still
	c rale sounds throughout, but denies difficulty breathing, chest pain. [redacted] Will
	obtain portable chest x-ray and inform Dr. Bergman [redacted]
(1620hrs)	Informed Dr [redacted] diminished sounds of SaO_2 ∆. Awaiting x-ray for CXR. Will obtain
	ABG now VIA aline. SaO_2 currently 93% on 15l O_2 via non-rebreather @ SOB
	@ difficulty breathing. Monitor and await further orders. [redacted]
(1640hrs)	ABG results:
	Dr [redacted] to consult c Radiology regarding CXR [redacted]
(1650hrs)	Patient to CT in EMT for R/O PE scan [redacted]
(1715hrs)	Patient set-up for CT scan (TOTAL body) R/O PE protocol. SaO_2 95% on NRB c O_2 @ 10-15l
	Will monitor while procedure is performed. [redacted]
(1750hrs)	CT scan completed. Dr [redacted] requesting an ~~at~~ ultrasound of the (B) LE veins to further R/O
	PE. Patient remains stable, SaO_2 c 95%. @ SOB or difficulty breathing. HR 120's
	To ultrasound via litter. [redacted]
(1815hrs)	Ultrasound completed of (B) LE deep veins. (unremarkable findings). To the unit to receive
	heparin 1,000u IV bolus, then Heparin drip. Also rec tx's q 4° c suction every other neb [redacted]

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[redacted] EPW

b(6)-4

PROGRESS NOTES
Medical Record

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[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0006 21Sept03	pt. on 50% venturi mask since 2200hrs q4° neb began
	@1600 hrs [illegible] from 1800 schedule q4° @
	04-08-12-1600-2000-2400 c every other suction
	pt spits up copious amounts of green/tan sputum
	suction via nasal trumpet also gets out moderate
	amount of secretions [illegible] suctioning down (R)-(L)
	bronchus. pt still [illegible] but improved [illegible] 50% →
	O2 sats 97%. IS [illegible] encourage coughing b(6)-2 [redacted] mask
0012 21Sept03	decreased amounts noted in Hemovac [illegible] @ 1900 otherwise
21 Sept 03	RT note: Pt awake Pre tx HR 110, RR 24, SpO_2 99 on 50% Venti
	mask. BBS CTA ↓ on L>R. UD Alb given. Post tx HR 113,
	RR 28, SpO_2 100% on 40%. nasal pharyngeal sx <3cc thick
	whitish. (+) productive cough. Will continue to monitor - [redacted]
	b(6)-2

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DATE	NOTES b(6)-2 AR
21 Sep 03 (0615hrs)	Assumed care of patient [redacted] D-of-shift report. See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial shift assessment. Pt. currently resting comfortably in bed [redacted] No/s/s distress.
(0815)	Received nebulizer breathing treat as ordered. Tolerated nasal/tracheal suctioning well [redacted] SaO_2. Currently SaO_2 99% [redacted] 40% Venturi mask. Shows no indications of resp compromise [redacted] Rt 29. Will pace incentive spirometer q1° and monitor [redacted] RT/AR
(0820hrs)	Order for portable CXR received from Dr [redacted] Portable CXR completed. Continues on Venturi mask (40%) ventilation on SaO_2 99%, no SOB or difficulty breathing. Plan to obtain sputum for cultures & gram [redacted] Mouth nebulizer tx via nasal suction & sputum catch. [redacted] RT/AR
(1121hrs)	ABG drawn via (L) Radial wrist stick per Dr. [redacted] Results: PH-7.46, PCO_2-36.1, PO_2-71 TCO_2-27, HCO_3-26, SO_2-95, BE-2. SaO_2 97% on Venturi mask @ 40% Will D/c to nasal cannula @ 4L [redacted] 1200hr Nebulizer treatment & suction, [redacted] RT/AR
(1215h)	Tolerated 1200hr nebulizer respiratory tx [redacted] Compromise or de-SATS. Sputum specimen obtained and dropped off @ microbiology. Pt switched to NC @ 4L. Current SaO_2 @ 98%. Plan to sit up in chair this afternoon. [redacted] RT/AR
21 Sep 03 (1230hrs)	Addendum Note: Pt given 4mg MSO_4 IVP for (R) flank discomfort & (R) LE discomfort. No significant changes to GI/GU or mems status since initial assessment. (+) facial grimacing & hold (R) flank of abdomen, as well as rubbing (R) thigh. Given @ 0915hrs [redacted] RT/AR

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b(6)-4

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b(6) -2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 Sep 03 (1530hrs)	CBC drawn from (R) SC catheter triple lumen ~ problems. Await results from LAB [redacted] /AN
21 Sep 03 (1553hrs)	CBC results c H&H 8.7/26.5 WBC 6.8. Results reviewed by Dr [redacted] AT/AN
21 Sep 03 (1615hrs)	Pt c SaO_2 now 94-95%. Lungs c improved breath sounds, but still c scattered rales @ production cough (green sputum). Received nebulizer tx & nasal/tracheal suctioning; stimulated cough c ↑ production of sputum expectorated. RR now 28 rpm and SaO_2 99-100%. @ respiratory distress/difficulty breathing [redacted] /AN
21 Sep 03 (1620hrs)	Given MSO4 4mg IVP for @ flank discomfort & analgesic prep prior to getting in chair. RR-31 SAO_2-99% c 4L O_2 NC. Plan to get patient up to chair within next hour [redacted] /AN
21 Sep 03 (1730hrs)	Pt OOB to chair on first attempt. Weight bearing (L) > (R). Has movement to (R) LE, but poor weight bearing. SaO_2 > 95% c 4L O_2 NC while sitting in chair. Tolerating OOB very well. RR ↓ to mid/high 20's. @ SOB or difficulty breathing displayed. Spontaneous, intermittent productive cough. Plan to leave pt up in chair and give S-of-shift report @ 1800hrs [redacted] /AN
22 Sept 03 0015	RT note: Pre tx HR 110, RR 25, SpO_2 95 on 2 LNC. BBS diff. Nurse took pt off tx, RT called to ER for trauma [redacted] 0115
22 Sept 03 0615	Assumed care of pt @ night shift, report given by Sgt [redacted]. Nasal airway to @ nare intact. On @ 4L/Min per NC. See assessment sheet. Will cont. to monitor. [redacted]
22 Sept 03 0630	D/C'd @ AC IV. Cath intact. Applied 2x2's & applied pressure. Secured c tape. Will cont. to monitor [redacted]
0700	IS used approx 10-12 x's. 5th ball raised (approx per sec). Will cont. to monitor [redacted]

[redacted] ACK

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
~~1000~~ ~~0950~~ 22 Sept 03	SPO2 ↓ 89%, NC A'd to simple face mask ↑ O2 @ 6L/Min per simple face Mask. SPO2 ↑ 96%. Will Cont. to monitor. [redacted]
1080	AM Lab RBC 2.75, Hgb 7.9, Hct 24.3. CBC redrawn & sent to lab. b(6)-2 A11
1180	CBC: RBC 2.68, Hgb 7.7 & Hct 23.9. MD notified of lab work. New Orders received @ 1200 to transfuse 2 u. PRBC & Cont. Neb q 2°. Blood drawn 1242 & sent to lab for type cross. Will Cont. to monitor. [redacted]
1350	DSG AD on Hemovac. Large amt drainage noted. Applied 4x4's. Secured c tape. Will cont. to monitor. [redacted]
~~1400~~ ~~1500~~ 1408	T 98.9 T, 101, 119/78 1st Unit PRBC started. Will Cont to Monitor. Lung Sound @ wheezing noted ↑ & ↓ lobes. @ diminished noted ↑ & ↓ lobes. Will Cont. to monitor. O2 @ 6L/Min per face mask (simple). [redacted]
1405	T 98.6 T, 116/71, R 22, SPO2 100%, P 103. Will Monitor
1410	BP 119/73 T&P 101, R 25, SPO2 97%, Lung Sounds: @ wheezing noted ↑ & ↓ lobes. @ diminished ↓ & ↑ lobes. Will cont. to monitor.
1415	T 98.8 T, P 99, SPO2 99%, BP 115/71, R 23. b(6)-2 [redacted]

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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 Sept 83	
1420	T 99.4 T, P104, SPO2 96%, BP 119/76, R 22
1425	T 99.1 T, P101, SPO2 96%, BP 120/73, R 29
1430	T 98.1 T, P98, SPO2 98%, BP 115/71, R 20
1445	T 99.2 T, P101, SPO2 97%, BP 120/74, R 18
1500	T 99.3 T, P105, SPO2 95% BP 121/76, R 24
1530	T 99.3 T, P103, SPO2 97% BP 117/71, R 32
1554/1600	T 99 T, P100, SPO2 96%, BP 115/73, R 34 1st Unit PRBC complete. Will Monitor Holy + clear yellow urine, LS (2) Slight wheezing noted RT + LL lobes. (R) diminished RT + LL lobes noted Will cont to Monitor
1620	2nd U PRBC started. VS before starting T 98 T, 100 P, BP 121/79
22 Sept 83	
1625	T 98.8 T, P105, SPO2 99%, BP 125/80, R 41
1630	T 98.6 T, P99, SPO2 100%, BP 124/79, R 26
1635	T 98.6 T, P100, SPO2 99%, BP 121/73, R 25
1640	T 98.5 T, P101, SPO2 99%, BP 122/71, R 29
1645	T 98.7 T, P101, SPO2 98%, BP 121/79, R 20
1650	T 99.3 T, P102, SPO2 99%, BP 122/76, R 25
205 1655	T 99.1 T, P102, SPO2 100%, BP 120/76, R 20
1720	T 99.6 T, P105, SPO2 98% BP 104/80, R 33
1750	T 99.1 T, P102, SPO2 98%, BP 122/77, R 26
1820	T 99.1 P 106 SPO2 99% BP 118/71 R 32
1822	blood transfusion over a.m. labs blood done
2200 2250	blood sent for a.m. labs.
2400	showed lab results to Dr. Bregman approved.
0345	pt continues to snore breath with cough + suction breathing tx a.m. Oxygen

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
23 Sept 03 0030	RT note: Pt awake. BBS coarse c slight wheezing L>R + rhonchi @ bases. Pre tx HR 108, RR 30, SpO_2 98% on 6L SM. UD Alb neb given. Post tx HR 117, RR 30, SpO_2 95% on 6L. Pt encouraged to deep breath. Pt moving about in bed (restless). BBS still coarse p tx. Will continue to monitor [redacted] b(6)-2
23 Sept 03 0605	RT note: Pt asleep but easily awaken. BBS coarse c faint wheezes. diminished @ bases. Pre tx HR 111, RR 16, SpO_2 98% on 10L SM. UD Alb tx given. Post tx HR 106, RR 26, SpO_2 98 on 6L SM. Sp to help pt cough. Advise pt to deep breath. Will continue to monitor. pt placed back on 6L SM [redacted]
23 sept 03 0630	- Received PT asleep in bed. VSS c spo2 @ 97 on 5 Liter Nasal. BBS coarse @ c @ Respiratory distress noted. PT b(6)-2 coughing. Crusty colored specimen. will attempt to get pt to cough and encourage incentive spirometer use. Pt tolerated neb treatment well. Distal cannot be flushed well, but good blood return. IVF presently infusing. Will continue to monitor pt for any respiratory change [redacted] b(6)-2 Cpn
23 sept 03 0900	- PT Given 20mg Lasix as per MD order. PT is Alert and Non-Responsive @ 10L spo2 91%. Sitting up on chair. Will Continue to monitor Pt. [redacted] b(6)-2 Cpn

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b(u)-4

EPW: [redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
23 Sept 03 1015	~~1015~~ PT Spo2 @ 98% on simple face mask AT 10L. Still encouraging PT to cough + Deep Breath. Placed PT Back in bed for comfort. Will cont to monitor for change. [redacted] b(u)-2
23 Sept 03 1430	- PT is currently on simple face mask 6L SAT 97-95%. PT having ⊝ Respiratory distress. PT still sounds coarse B/lateral. Also tolerated neb treatment well. PT is currently ~~[illegible]~~ Angled ⊕ AT 45° level of Bed, resting comfortably ē ⊝ % pain. Will cont to monitor for Δ's. [redacted] b(u)-2
23 Sept 03 1730	- PT is currently on nasal canula 2L O2 SAT 97%. ⊝ Respiratory distress or discomfort. Will cont to monitor [redacted] b(u)-2
2000	NT SUCTION c̄ WHITISH YELLOW SPUTUM. PT ⊕ GAG REFLEX COUGH UP WHITISH YELLOW SPUTUM. SaO2 ↓ TO 89%. PT PLACED ON SFM @ 8L. WILL MONITOR. [redacted]
2200	ANCEF 1GM GIVEN; ATIVAN 1MG GIVEN. NT SUCTION c̄ WHITISH THICK FROTHY SPUTUM. PT COUGHED UP THE SAME. SFM ↓ TO 6L. WILL MONITOR. [redacted] b(u)-2
2300	VSS - PT c̄ c/o PAIN MEDICATED c̄ 2MG MSO4 IVP. PT SaO2 97% - 96%. AFTER REDUCING TO 6L SFM. WILL CONTINUE TO MONITOR [redacted]
24 Sept 03 0000	NT SUCTION c̄ WHITISH THICK SPUTUM. ∅ ORAL FROM PT. SaO2 96% ON 6L SFM. WILL MONITOR [redacted]
0200	NT SUCTION c̄ WHITISH FROTHY SECRETIONS ∅ ORAL [redacted] b(u)-2 PT PLACED ON NC @ 4L. O2 SATS @ 99 ON 6L SFM @ THIS TIME. WILL CONTINUE TO MONITOR AND TITRATE [redacted]
0400	VSS AFEBRILE. LABS SENT. PT RECEIVED MSO4 2MG FOR c/o ABD ↓ ↓. PT UTILIZING I?S. ∅ 2° THROUGHOUT SHIFT. PT ... WILL CONTINUE TO

b(u)-4 [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0600	REPORT GIVEN TO SGT [redacted]. VSS AFEBRILE. PT SUCTIONED VIA NT C SM AMOUNT WHITE THICK SECRETIONS. PT RA 2½L NC SaO2 @ 96%. [redacted]
24SEPT 03	+ Reward PT Alert [redacted] verbal stimuli, awake in bed.
0600	⊖ c/o pain or discomfort. Bilateral rise + fall of chest + clear sounds on upper lungs. PT is currently on 4L NC SaO2 97%. ⊖ Respiratory distress at current time. Pulse prox on all extremity + good flow. +3 see cap ref. Heart ausc ® side currently drained 10cc Bright red blood. ⊖ s/s of infection noted & site is CDI. PTs Foley draining clear color urine. Will encourage PT to move to obtain today's cath + Deep breathe. [redacted]
24SEPT 03	- NO reward PT Hrassek. PT has ⊖ c/o pain or
1635	discomfort. Will continue to monitor [redacted]
1815	Received report from SGT [redacted]. VSS, temp 101°, Neb treatment given by RT @ this time, SaO2 100%. HOB @ 45°. Nasal trumpet to ® nostril for suctioning. Unable to flush proximal or distal port of subclavian lines. RT placed pt. on NC @ 4LPM, SaO2 of 96%, will continue to monitor. -SPC [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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[redacted]

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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2100	O_2 reduced to 2LPM via NC, S_aO_2 @ 98%, will continue to monitor ——— SPC [redacted]
2200	Pt. up to bedside chair, copious amounts of light green phlegm were coughed up by pt. S_aO_2 ↓ to 82-84 percent, simple face mask put on @ 8LPM + 10LPM, S_aO_2 remained below 86%. Pt. returned to bed + put on non-rebreather face mask. S_aO_2 increased to 100% @ this time. Pt. suctioned through nasal trumpet, S_aO_2 remained at 98% ⊕, simple face mask put back on @ 6Lpm + S_aO_2 remaining above 98%. Will continue to monitor. ——— SPC [redacted]
0030	Pt. placed on NC @ 4LPM, S_aO_2 98% — SPC [redacted]
0200	O_2 turned off, pt on RA S_aO_2 @ 99%, will continue to monitor ——— SP [redacted]
0440	Pt. suctioned + put on simple mask @ 6LPM for S_aO_2 ↓ to 84%, S_aO_2 ↑ to 94%, will continue to monitor SPC [redacted]
0600	Assumed care of pt. VSS. will continue to monitor. SPC [redacted]
1630	MD made rounds @ bedside. Dr [redacted] wanting pt to wean off O_2 from FM & NC. pt fully awake, cooperative, calm D/C (R) nasal trumpet. D/C FM @ 6L. pt able to use incentive spirometry & difficulty able to raise one bed. S_aO_2 reading 96% in room air. will monitor closely for resp. status. ———
1700	S_aO_2 97% in RA for > 30 min. O_2 D/C for now. [redacted]

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DATE	NOTES
1710	pt resting comfortably, no resp. difficulties noted. Continue monitor and encourage incentive spirometry - [redacted] b(6)-2

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# [redacted] b(6)-4		

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1845	Received report and took over care of pt.
25 Sep 03	@ this time. Pt. resting in bed, HOB @ 45°. SPC [redacted]
2010	Pt. consumed 25% of CL diet, tolerated well
	c̄ ⊖ SS N/V. b(6)-2 SPC [redacted]
2300	Pt. repositioned in bed to a more comfortable
	position b(6)-2 SPC [redacted]
0230	Pt. spoke c̄ translator @ this time, ⊖ c/o pain/discomfort
	@ this time. MSO4 from 0100 had a ⊖ affect. SPC [redacted]
26 Sep Ø6Ø5	Assumed care of pt. VSS. Pt resting in bed c̄ eyes b(6)-2
	open. will continue to monitor. SPC [redacted]
Ø915	Got pt up to chair. Pt desated, put pt on non rebreather
	Monitored pt for 1 hr. Put pt
26 Sep	Nutrition Consult: Pt tol CLD well. Recommend adv
1200	to FLD. If pt tol FLD well, adv to regular to meet pt's
	ENN: 2100-2450 (30-35 kcal/kg) + 91-105 g Pro/day
	(1.3-1.5 g/kg) [redacted] RD/LD b(6)-2
	Temp 1Ø2 Sats 9Ø ↓ CPT, SP
26 SEPT	- PT Given 4mg morphine by [illegible] VSS HR 146, R 39 126/101
1515	PT is SAT 90% on 15 non-Rebreather Trach 24 cm @ Teeth - 1537
	Sats 98% BVM, 2 cultures? - A-line @ 1530. Triple lumen
	@ 1545. Pulse 138 BP 144/56 R 19 O2 98%

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EPW [redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 SEP 03 @1530	ANESTHESIA: Called to ICU2 for emergent intubation, pt having noted respiratory distress. SaO_2 87% and falling. 200mg Propofol and 100mg SUX given, DL x2 miller 2 Grade I view, 8.0 ETT placed 24 cm @ lip (+) BBS, VSS and remain [redacted] SaO_2 improved to 100% post intubation. [redacted] CPT, AN, CRNA b(6)-2
26 Sep 03 1500	Late entry. Called to bedside. pt having acute episode of respiratory distress. pt shacking and shivering. 100% NRB on. pt anxious, tacypnic respiratory rate 50's. SaO_2 72%. unable to raise O_2. ↑ HOB to 45°. Called interpreter to bedside. Through the interpreter, pt states he is not able to breath. Coughing up thick cream color sputum x2. Lungs - course rhonchi bilaterally plus wheezing noted to (L) side of lung fields. (R) lower base crackles auscultated. anesthesia and MD's called to bedside. Dr. Mulloy and anesthesia ~~team~~ team @ bedside. pt given 20mg IVP given @ 1440 by CPT Puzzet. pt intubated by anesthesia using 8.0 cm ETT via orally, and taped @ 24 cm to lip. Good bilateral breath sounds auscultated. attempted A-line stick x2 s̄ success. placed A-line to (L) radial per Dr. [redacted]

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b(6)-2 MAJ AN

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 Sep 03 2000	VS: T100' HR 116 91/59 [redacted]
26 Sep 03 2010	119 BP 95/60 R15 - Tolerating well [redacted]
2035	VS: HR 115 BP 91/59 R 14 T 100' 98% [redacted]
[redacted]	Completed Version Transfusion [redacted]
2040	[redacted] started Tolerating 2nd unit PRBC (started @ 2030) HR 114 BP 86/57 14 97% [redacted]
26 Sep 2050	HR 114, BP 86/57 T100 [redacted]
2100	T 99.6 HR 111 BP 97/59 98%. No complications [redacted]
2115	99.6 HR 115 95/60 R14 [redacted]
2130	HR 110 BP 95/58 [redacted]
2145	T 99.6 HR 110 BP 92/57 R14 SpO2 99% Tolerated transfusion well completed 2nd unit. [redacted]
27 Sep 03 0200	Pt comfortable. Sedated on previously mentioned [redacted] VSS. Currently weaning FIO2 vent SIMV R 12 PIO TV 800 FIO2 55% SpO2 92-99%. Cont. c antibiotic therapy. No changes in status will cont. to monitor [redacted]
27 Sep 03 0530	Pt c stable VS. No changes in status. Resting, NVI and sedatives and paralytic. MAP 70-80's. IV's patent & care done. Scant amt secretions. Will cont. to monitor [redacted]
0630	Assumed care of pt resting comfortably in bed sedated c versed 5mg/hr + NS 80, 4mg/hr. Paralyzed c vec @ 7mg/hr. Dr DA 4700 for initial assessment. Will continue to monitor [redacted] c/o
1000	Pt continues to rest comfortably in bed sedation remains the same. Vent settings changed to SIMV 12, TV 800, Peep 10, FIO2 40%. Will continue to monitor and obtain ABG in 30 minutes [redacted]

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DATE	NOTES
~~26Sep03~~ 1845	T/c 4/u PRBC, vanc @ Bedside c Neosynephrine to Bedside. b(6)-2 CPT [redacted]
26Sep03 1840	Assumed care of pt from previous shift. Pt currently sedated c versed c 5mg/hr, MSO4 4mg/hr, Vecuronium c ~~3~~ 4mg/hr. currently infusing c 1.2 mcg/kg/min. Receiving heparin c 1000u/hr. Intubated c vent c SIMV R14 P10 TV 800 100%. Labs drawn for CBC and T+C. #8.0 24c teeth. ABG drawn and results given to Dr [redacted] b(6)-2 18G started on (L) FA. Vancomycin started. Midline abdominal incision c steristrips No distress noted c present Will cont. to monitor — [redacted] b(6)-2
26Sep03 2000	Remains on above mentioned vent settings Vecuronium infusing c 7mg/hr. (R) breath sounds auscultated (R) mid and lower lobes diminished c crackles to (R) side CTA on (L) lobes. Palpable pulses 2+ Cap refill 3secs. Bowel sounds x 4 quads. Drsg to RLQ from old ~~drain~~ site no drainage noted. Midline incision intact c steristrips. foley to BSO. c dark yellow-amber urine. (R)SC triple lumen intact and patent. IVFDs ½NS c 20KCl c 150/hr. Tolerating PRBC transfusion c complications H/H 7.6/24.9. @ Rad Aline b(6)-2 intact MAP 60-67. Will cont. to monitor status [redacted]
Latter ~~1945~~ 1945	VS 100' HR 117 BP 88/57 started transfusion @ 1940
1950	HR 117 T 100' BP 92/59 b(6)-2 [redacted]

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DATE	NOTES
26Sep03 1600	A-line pressure bag intact. A-line zeroed and calibrated. Labs drawn and sent to lab. CBC, PT/pTT, ABG, Lytes. Portable CXR done. Central line placement done per Dr. [redacted]. (R) subclavian line successful 1st attempt. all lines flushed and patent. portable CXR done for placement check. MSO4 4mg/Versed 4mg IVP given prior to Intubation. SaO2 ↑ 100% for 20 minutes of intubation. CXR confirmed by MD. ordered to DC (L) central line. ordered to pull back 2cm.
1630	RT pulled back 2cm. shared care for better ET securement. ABG results for 16:15. pH 7.411 pCO2, 40.1. PO2 73. HCO3, 26 BE 1mm SO2 95%. Vent settings: TV 800 FIO2 100% Rate 14. Peep 5. pt sedated c Versed drip 50mg/50ml NS @ 6mg/hr. MSO4 50mg/50ml NS @ 7mg/hr. Vecuronium 50mg/50ml NS @ 7mg/hr. HR 147 Dr. Storey b(6)-2 BP 126/63 Rate 14. SaO2 95% [redacted] RT AJA.

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 Sept 1645	All IVF's infusing per (R) subclavian Triple lumen cath. Blood culture X2 drawn. Drip #2 Ons per (R) subclavian, Drip from (L) radial A-line. D5 1/2NS @ 20KCL @ 125 c/hr via pump. Pt sedated, no agitation noted [redacted] MAT Ac
1720	ABG Results TCO2 - 27mmol/L, At 37C, PH - 7.449, PCO2 - 37.6 mmHg, PO2 - 53 mmHg, HCO3 - 26mmol/L, BE ecf 2mmol/L SO2 - 88%. SPC [redacted] 9/WM6
1835	Pt given total 1000cc NS Bolus x1 And 200cc total of 25% Albumin for low BP & PEEP ↑ From 7 to 10. SIMV RR14 TV 800 FIO2 100%. ABG @ 1800: 7.4/38/73/25/0 Pt has been on 100% FIO2 since intubation @ 1515. Pt has desatted into the high 80's c 100% FIO2 - Dr Mulligan aware - when bagged pt desated even lower. No PEEP valve on Ambu BAG. Pt c MAP 59-61 since PEEP ↑ to 10: Pt has BBS, CTA, clear when suctioned via ETT. ETT #8, 22@lip - taped to (R) side of mouth. Versed @ 5mg°, 7mg total, Vec. 1.2mg kg-min and Heparin @ 1000 units/hr. No Bolus of Heparin given PT/APTT & Heparin began 15.5/27.4 sec. Next coag due to at 2300. No parameters given per Dr [redacted] @ this time. Report given to CPT Weston - pt supine in bed c HR 120's/BP 89/56 (67)/RR 14/SPO2 96% c 100% FIO2. (L) RADIAL ART intact c good waveform — CPT [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
#[redacted]			

DATE	NOTES
26 Sept 03 0040	Pt being moved by nurse. Pre tx HR 121, RR 32, 92% SpO2 on RA. UD Alb neb given via aerosol mask. Post tx HR 118, RR 30, SpO2 97% on RA. ——— Sgt [redacted] 9IV19
26 Sep 03 0610	Pt awakens easily. Pre tx HR 119, RR 32, SpO2 90 @ RA. UD Alb neb given. BBS CTA c bases slightly diminished. Post tx HR 112, RR 30, SpO2 90. IS done ——— Sgt [redacted] Pt placed back on 5L NC Sp02 92% ——— Sgt [redacted]
27 Sep 03 0610	Pt intubated. Settings SIMV 12 800 50% +10, PIP 36, HR 105, SpO2 97%. No new orders written post intubation BBS coarse @ wheezing. HME placed in line. Neb tx given per nurse request. Told nurse to either ask MD to resume orders or write new one or the tx will be canceled. Pt was intubated due to respiration distress earlier in day 26 Sep 03 about 1500. Doctors states suspect P.E. Pt's ABG as of 0515 27 Sept 03 are as follows 7.43/39/137/26/2/99%. Will continue to monitor ——— Sgt [redacted] 9IV29
	Pt. given UD Alb & UD Atrovent via in line @ 9Sp: P 95-104 RR 19-17 BBS CTA
10 Oct 03 1800	UD Alb tx given Pre tx HR 92 RR 16 SpO2 98% Post Tx HR 100 RR 16 SpO2 99% BBS coarse Pt Sectioned < 5cc watery secretions removed Sgt [redacted] 9IV20
10 Oct 03	UD Alb tx via in line Pre Tx HR 120 RR 24 SpO2 94% on 40% FiO2 BS Coarse Post tx HR 124 RR 18 SpO2 97% Pt Sectioned removed 8cc clear secretions BS no change Sgt [redacted] 9IV26

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b(6)-2
All

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DATE	NOTES
24 Sept 03 0615	RT note: Pt awake. Pre tx HR 103, RR 24, SPO_2 95% on 3 L NC. UD Alb given via aerosol mask. Post BBS diminished. Post tx HR 105, RR 29, SPO_2 99% on 3L NC. IS done with weak effort. Sx done. Will continue to monitor — b(6)-2 Sgt [redacted]
24 Sept 1815	RT NOTE: Pre Tx HR 114 RR 25 SPO_2 99% on 4L BBS Diminished UD Alb tx given Post tx HR 115 RR 30 SPO_2 98% BBS NO change — b(6)-2 Sgt [redacted] 91U
24 Sept 2330	Rt note: Pt awake. Pre tx HR 115, RR 31, SPO_2 100% on 6L SM. BBS diminished but clear upper lobes. UD Alb neb given via aerosol mask. Post tx HR 121, RR 32, SPO_2 100% on 4L NC. Pt suctioned ~ scant amount. Pt cough ~ thick yellow. IS done with weak effort probably dued to language barrier. — b(6)-2 Sg[redacted]
25 Sept 03 0615	Pt awakes easily. Pre tx HR 105, RR 24, SPO_2 99 on 6L SM. UD Alb neb given via aerosol mask. BBS faint wheezing otherwise diminished. Post tx HR 105, RR 26, SPO_2 98-99% on 6L. Pt on RA SPO_2 94-97% will continue to monitor — b(6)-2 [redacted] 91U
25 Sept 03 1823	Pt awake & alert Pre tx HR 109 RR 24 SPO2 95% on RA. BBS Diminished Post tx HR 109 RR 34 SPO2 94% on RA BBS Diminished Lower lobes — b(6)-2 Sgt [redacted] 91U

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b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27Sep03 2140	HR 112 BP 132/57 R17 96% T101° [redacted]
2145	HR 117 145/67 R17 91%. Pt rec'd Tylenol supposit by [redacted]
27Sep03 2150	HR 122 T102° BP 154/72 R16 95% [redacted]
27 Sep 2220	HR 112 BP 125/46 95% T101.5 ~~R22~~ [redacted]
27Sep03 2300	Pt tolerating transfusion well No distress noted. Pt c bruise to lower back and (L) ~~lower~~ hip area [redacted]
27 Sep 2305	Completed transfusion HR 116 T101° 144/68 Tolerated well [redacted] Will cont. to monitor
28Sept03	assumed care of pt. Versed/MSO4/Rec for sedation.
0000	Heparin @ 1000u/Hr + D5 1/2NS ROR @125. VSS. Pt supine @this time. Will turn Q2. CTM — CPT [redacted]
0800	pt turned to (R) side. Suctioned @ 1° ETT + orally. SIMV R16/800/50%. 10. SaO2 97%. — CPT [redacted]
1000	Pts 1 VABX given per schedule. Pt turned to (R) side. CTM. — CPT [redacted]
1300	NGT placed to (R) nare. CXR portable ordered to verify placement. Will attatch to LWS upon verification by MD. VSS. Atrvan d/c'ed. POC: Begin feeds this morning at 1a.m. of Osmolite. Goal rate 100cc/hr. CTM — CPT [redacted]
1700	Pt turned Q2°, Suctioned via 1° + prn via ETT and orally. Yellowish thick secretions via ETT / white thin secretions via oral cavity. VSS. Rec/Versed/MSO4 decreased for 1-2 twitches / NTE 4 twitches. Per Dr. [redacted] NGT TO LWS + thin watery light green fluid being removed. Coag/CBC/met 8/ABG drawn @ 1700. Awaiting results. VSS — CPT [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27Sept03 1110	FIO_2 increased to 50% secondary to PO_2 being 62 on last ABG. Will repeat ABG in 30 minutes b(6)-2 [redacted]
1300	Pt c increased secretions noted via ETT. Thick brown secretions suctioned p pt's O_2 sat dropped to 92. FIO_2 increased to 60% c ABG to follow b(6)-2 [redacted]
1402	Pt c temp of 101.3. Tylenol 650mg PR given per pharmacy orders will continue to monitor b(6)-2 [redacted]
1600	Pt c 1 O_2 sat p being suctioned. Will continue to monitor ~~27Sep03~~ b(6)-2 [redacted]
27Sep03 1800	Rec'd report from previous shift. On ventilator SIMV R 16 PIP TV 800 FIO_2 60%. Sedated c versed @ 5mg/hr MSO4 4mg/hr and Vecuronium 7mg/hr. Receiving D5½NS c 20KCl @125/hr Heparin @1000u/hr. Pt c @ rhonchi diminished breath sounds to RLL suctioning thick yellowish secretions orally and via ETT palpable pulses @ lt. Edema Abd round soft c hypoact bowel sounds. Midline abdominal incision intact c steristrips to site. Old drain site c no new drainage Foley D BSO c amber urine. USS. (R) sc triple lumen, (L) Rad Aline and 18G PIV. Will cont. to monitor-suctio
27Sep03 2135 ~~2130~~	Pt ~~transfused~~ Started 4u PRBC H/H 8.9/28.8 Tolerating well. IVF cont. to infuse No distress b(6)-2 [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	weaned to 50%. FIO2 ↓ SPO2 >93%. Ave. abt 95%. Suctioning @ 1° ↓ Neb tx per order. Pt began to desat to low 90-92% ↓ 50%. FIO2 - currently @ 60%. FIO2 ↓ SPO2 ~94-95%. VSS @ this time. Yo ~ 100-200cc amber concentrated urine. ABG/coags/CBC/LFT sent off @ 1700. Report given to CPT weston. ——— CPT [redacted]
29Sep03 1800	Rec'd report from previous shift. VSS febrile. Sedated versed 5mg/hr, MSO4 @ 5mg/hr and vecuronium @ 4mg/hr. Pupils 1mm non reactive jaundiced sclera. #8.0 ETT 24@ teeth. SIMV R16 P10 TV 800 60%. Lungs coarse @ suctioning thick yellow secretions via ETT and orally. Palpable pulses @ 1+ Abd round distended ↓ absent bowel sounds. Midline incision intact ↓ steristrips ⊗ site ⊗ drainage. NGT to @ nare LIS. foley cath BSO ↓ amber colored urine. (R) SC triple lumen cath intact (L) Radial aline intact BG to @ LA. Heparin infusing @ 1000u/h and D5 1/2NS ↓ 20KCl @ 125/hr. Will cont. to monitor — [redacted]
30Sep03 0100	Pt ↓ any changes in status Temp decreased 100.4 Weaned FIO2 to 50%. Pt tolerating well ↓ SpO2 96-99%. AM care done Pt noted to have yeast ⊗ groin area, rash to inner thigh area bilat scrotum. Will discuss ↓ physician in AM. Labs drawn K+ 2.9 Ordered KCl gtt per Dr [redacted]. Will cont. to monitor — [redacted]
0600	Pt ↓ any changes. Rec'd 1st KCl bolus ↓ complications IV lines patent. Labs drawn. No dishes noted ——— [redacted] MT

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b(6)-2 AM

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
0330	PT C PEAK PRESSURE @ 47. ETT SUCTION DONE PASSING SUCTION x3 C RESULTANT COPIOUS THICK WHITISH YELLOW SECRETIONS. PT PEAK PRESSURE ↓ TO 33. SpO2 MAINTAINED @ 96-97%. WILL CONTINUE TO MONITOR. [redacted]
0500	LABS SENT. CBC AND COAG [redacted]
LE 0610	BED BATH GIVEN. FOLEY CARE DONE. MOUTH CARE DONE C ORAL SUCTION AND CHLORHEXINE SWABS. DRSG TO PEG CHANGED PREVIOUS DRSG C NICKEL SIZE SEROUS DRAINAGE. Ø S/S INFECTION. BED LINEN CHANGED AND PT REPOSITIONED [redacted]
29/9/03 1500	PT assumed care of @ 0600. Use, Intubated sedated c SpO2 -97%.. SIMV R 16/800/50%/5/PS 7%. SpO2. Uneventful day until 1100 when pt went to CT Scan for chest/abd pelvis contrast via orally + IV. Pt where received CT Scan d/t she could not maintain her SpO2 C FiO2 @ 100%, PT ↑ to 10 from 5. Aggressive suctioning By RN & RT. CXR done - pulled ETT back 2 cm - Raised pt to 20° angle then SpO2 ↑ 91-94%. Pt returned to ICU & put back on vent and was able to maintain SpO2 - 100%. C 100% FiO2. Pt then

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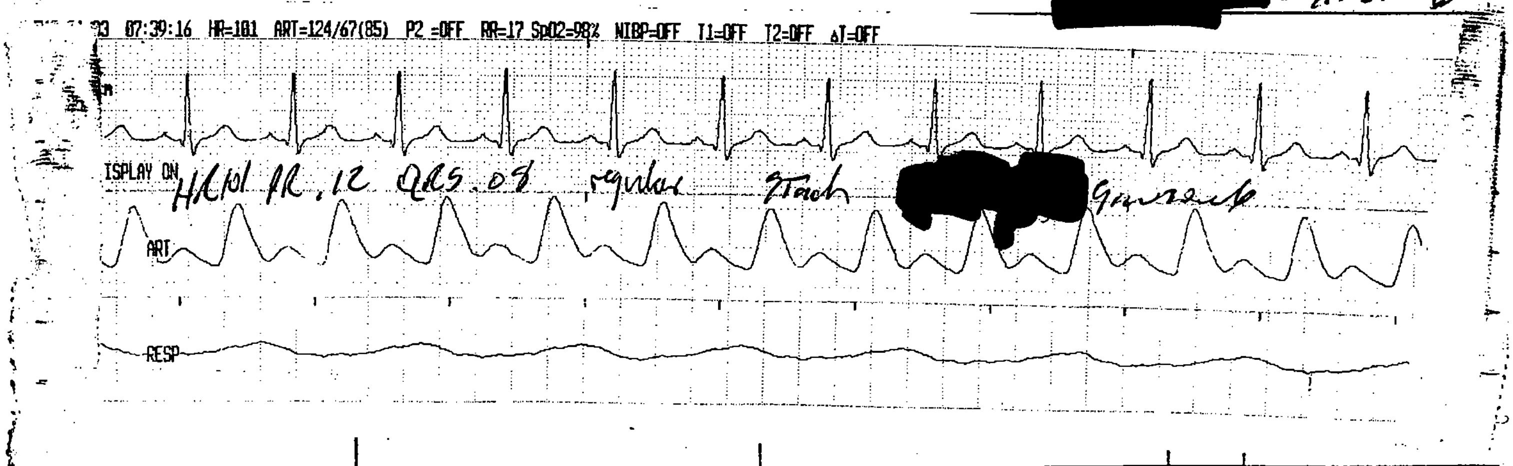
MEDICAL RECORD	PROGRESS NOTES b(6)-2

DATE	NOTES
30 Sept 03 1800	Rec'd report from previous shift. SpO_2 90-92%. Suctioned orally and via ETT c̄ thick yellowish secretions. Then increased to 95%. Meds currently infusing versed 5mg/hr MSO4 5mg/hr and vecuronium 4mg/hr. D5 1/2 NS c̄ 20KCl @125/hr. Heparin 1000u/hr. Cont. c̄ antibiotic therapy. NGT to LIS to (R) nare. Foley c̄ amber urine. Will cont. to monitor status [redacted]
1 Oct 03 0400	Pt febrile 100. Measures taken through night to decrease temp. AM care done. No changes in status. (R) SC triple lumen and (L) FA PIV intact and patent. (L) Rad A line intact. No distress noted. Copious amt secretions suctioned. Will cont. to monitor [redacted]
1-OCT-03 0630	VS 11/60 - 99° - 104 - 17 - 98% SpO_2 on SIMV Rate 16, PEEP 5, TV 800 FiO_2 40%, #8 ETT, 24 cm @ teeth. Assessment on [illegible] FBG OP 395 dated 1-OCT-03. Received report. Will monitor. [redacted] [illegible]



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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
1-10-03 1000	VSS. Pt transported to and from CT @ 1000 hrs. Pt tolerated transport c difficulty. Pt's ABG drawn 2° to Dr. ~~Acid Fast Acetobacter~~ ∅ vent changes noted to new ABG. Will cont to monitor ——— [redacted]
1-10-03 1600	VSS 96-98?-108/56-16-96% spO2 on [redacted] SIMV 16, PEEP 5 TV 800, FiO2 40%. Pt suctioned and produced thick yellowish frothy secretions from ETT. Pt's lab results from C+S returned. Pt + for Acinetobacter. Will monitor [redacted]
1 Oct 03 1800	Rec'd report from previous shift VSS. Sedated versed 5mg/hr, MSO4 5mg/hr, vecuronium 4mg/hr vent SIMV R16 TV800 P5, FiO2 40%. Thick whitish secretions. Pupils sluggish but reactive 2mm. Equal chest expansion. Coarse BBS. Palpable pulses ∅ edema. (R) SC triple lumen (L) Radial Aline PIV x1. Abd round soft c absent bowel sounds NGT to (R) nare LIS. Midline Abd. incision intact c steri strips to site. Foley to BSD c amber urine. Currently infusing Heparin 1000u/hr D5 ½NS c 20 KCl @ 125/hr Will cont. to monitor ——— [redacted]
2 Oct 03 0000	Pt s any changes in status VS remain stable Dobhoff tube placed to (L) nare per Dr Mulligan placement confirmed via XR clamped @ present. IVF cont. to infuse. Bruise remains to (L) back/hip area. No distress noted ——— [redacted]
2 Oct 03 0425	20G IV placed to (L) FA AM care done. No changes in status Will cont to monitor ——— [redacted]
2-Oct-03 0623	VSS, Assumed care of Pt, Pt sedated and paralyzed c MSO4 IV gtt, Versed gtt, and Vecuronium gtt. VENT - #8 ETT, 24 cm @ lip, SIMV 16 Peep 5, TV800, FiO2 40%, Assessment on [redacted] dated 2-Oct-03. Will monitor ——— (b)(2)-2 [redacted]

[redacted] 09 (REV. 5/1999) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2 Oct-03 1000	Pt open eyes, Pt rearoused and pt nodded head. Vent SIMV, 16 TV 800, PEEP 5, FiO_2 40%, VSS, UOP > 100 cc/hr amber clear Q2° turning. Pt dressing intact, lung sounds coarse @. Pt suctioned → produced thick clear slight blood tinged sputum.
2-Oct-03 1100	Pt started on Tube feedings per ~~Kopp~~ Dopkoff Dopkoff tube. Placement checked @ 20 cm o/r. Feeding was started but IV pump indicated back flow from tube. I attempted to draw back on tube @ a syringe @ no success. Will notify MD. Pt VSS. NG Tube clamped. [redacted] 1556 2/10/03 0048
2-Oct-03 1600	Dr. [redacted] states try Coca cola to break up clot in Dopkoff. 1st attempt no success.
02 Oct 03 1800	received report from outgoing Shift. Initial assessment on DA 4700. VSS NAD attempted to unclogge dobkoff without Sucess @ Coca cola per MD order unsuccessful. MD notified [redacted] 91WMe
02 Oct 03 1930	-Dobkoff (L) nare difficult to remove Dr. [redacted] notified - Dr. [redacted] Dr. [redacted] MD CXR - PT VSS NAD. SGT W[redacted] 91WMe
2000	CXR complete - Dr. [redacted] stated x ray

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b(6) - 2 AM

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Unremarkable - Dobhoff advanced then removed 5 difficulty VSS NAD. SGT [redacted] 9 hrs
020ct03 0230	Dobhoff placed (L) nare tolerated well NAD NG tube D/ced SGT [redacted]
~~030ct03~~ 0200	- pt bath provided foley care provided linen Δ'ed - Bite blocked Δ'd by PT mouth care provided tolerated well pt positioned (R) side posterior aspect skin integrity intact noted medial thighs bg groin skin erythemic & whitish top. Odor. will inform MD in am VSS NAD SGT [redacted] 9 hrs
Late entry 2230	p Dobhoff placement - KUB - Dr [redacted] viewed X-ray. Osmolyte @ 10cc/hr. & residual ✓ per MD order will cont to monitor SGT [redacted] 9 hrs
2300	Residual from Dobhoff ↓ 5cc Osmolyte 15 cc green bile SGT [redacted]
~~030ct~~ 2400	Residual from Dobhoff 10cc ~~blat~~ bile (green) SGT [redacted]
0100	- Residual from Dobhoff 5cc green bile SGT [redacted]
0200	- Residual from Dobhoff 5cc green bile SGT [redacted]
0300	Residual from Dobhoff 10cc green bile SGT [redacted] 9 hrs

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DATE	NOTES
030ct03 0500	dobhoff residual 5cc. Sent [redacted]
0600	dobhoff residual 10cc. Green bile 1/3 was Osmolyte Sent [redacted]
3-Oct-03 0625	VSS, PT responsive to touch, Assistant on [redacted] OR 375 dated 3-Oct-03. Vent settings SIMV, 16, TV 800, F:02 40%. 8.0 ETT 29cm @ teeth, will monitor ABG [redacted]
3-Oct-03 0900	Vent Rate d/d to 8 BPM per Dr. [redacted]. PT has additional breaths against the vent. Will check ABG in 30 minutes. [redacted]
3-Oct-03 1000	PT's ABG came back. Values noted on Flowsheet [redacted]
1025	Dr. [redacted] informed of pt's ABG results. He was satisfied = PaO2 78%. Pt's RR V to 4 BPM And 7102 @ 45%. ABG to be done @ 1100. -CR [redacted]
4-Oct-03 1205	PT extubated by Dr. [redacted] VS 122/66-99-97-28-100% SpO2 via venturi mask. PT alert, oral cough and deep breath, coughed clear thick sputum post extubation. Lungs coarse (B), equal rise and fall of chest & accessory muscle use. [redacted]
3-Oct-03 1405	VS 122/81-99-97-28-96% SpO2 on RA, PT AOx3, on [redacted], IS in use @ 1000 cc. Lungs, Clear. BS, ↓ RLL, [redacted] accessory use. [redacted]

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EPW [redacted]

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b(6)-4

LAST NAME	[redacted]	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3 Oct 03 1540	RT sitting up in bed c̄ assistance. NEB Tx given, wheezes heard (B) side lung. Chest PT performed c̄ RT, pt. coughing up very little clear to yellow mucous. RT SpO2 ↓ 88 and he was placed on NRB @ 15 LPM producing SpO2 at 94%. After 20 minutes ~~pt was~~ 1520, pt was placed in bed. He was Δ'd to a venturi mask at 50% O2. Will monitor b(6)-2 [redacted]
03OCT03 2120	Assumed care of pt @ 1800. VSS, temp 99°, now 99.4° A+O. lung sounds clear bilaterally apex to base, c̄ diminished bases bilaterally. O2 Sat 94-97% on venturi mask @ 50% RR 29-40's. Ø use of accessory muscles noted. Encouraged to use IS. Radial + Pedal pulses strong & equal to palpation bilaterally. Cap Refill < 3 sec to all extremities. PERRL 4mm. Mucous membranes moist. Pt allowed sips of water. Pt has (R) triple lumen, CDI, Ø redness or infiltration noted. ~~(R)~~ MEF (L) Radial A line, Ø redness ~~or~~ MEF or infiltration noted. Pt has Steri Strips to midline abdomen, CDI, Ø drainage noted. Pt has dressing to RLQ, Ø drainage noted. BS active x4 Quadrants Ø tender, Ø distended soft. Pt has foley to gravity draining light amber colored urine. Pt has complete ROM to all extremities. BLE stiff & slightly painful c̄ movement. Will continue to monitor for Δ's. Continues on IV abx. —— b(6)-2 SPC [redacted] 91WM6
04OCT03 0036	Pt lab results showed PHS to be 827. MD notified. No action taken per MD assessment. Will continue to monitor. — SPC [redacted] 91WM
0500 ~~0030~~ MEF	CBC, PT/PTT, & Chem 8 sent to lab. Will continue to monitor & report results to MD —— b(6)-2 SPC [redacted] 91WM
LE 0200	Pt placed on 4L O2, humidified by RT. Δ'd to 5L O2 via NC @ 0300 due to O2 Sat of 91%. Will continue to monitor. — SPC [redacted] 91W b(6)-2

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
04Oct03	switch to non rebreather 15l SaO_2 ↑ 92% –
cont	94%. pt sitted up c̄ feet over edge of
	bed – chest pt to posterior – ⊕ pro
	sputum – noted BM liquid strong smell
	ABD soft NT ⊖ DTN BS active x4. Steri
	strip midline abd intact ⊖ drg noted
	a line Ⓛ wrist removed, Ⓡ SC line Ru
	D5 ½ NS c̄ 20K @ 125 ml/hr will cont to monitor, SGT
04 Oct 03 0440	RT note: ABG FiO_2 50% VM: 7.48/3?.9/114/24/1/99% – SGT [redacted] b(6)-2
04Oct03	– Desat 78% c̄ NR 15l – positioned b(6)-2
2100	in bed. R-56 – bagged c̄ 15l O_2 color
late	pale – ⊕ diaphoresis denies CP. incident
entry	occurred while pt standing c̄ assist for
	linen Δ. RT called. HOB ↑ 90% – SaO_2
	95% 15l O_2 NR after bagging color good.
	ABG – 7.472, pCO_2 33.5 pO_2 51 BE-1 b(6)-2
	HCO_3 24 SaO_2 89 physician notified Dr [redacted]
	will monitor closely SGT [redacted] 91W
04Oct03	– VSS IS – nebs per MD order q2 c̄
2300	chest pt c̄ assist from RT. SaO_2 96-98%
	15l venturi. c̄ cont to monitor SGT
0200	– VSS SaO_2 99% 15l venti
	Albuterol + chest pt c̄ IS q2°.
	pt doing well NAD. each chest pt
	⊕ production is amt yellow tinged
	mucus – will cont to monitor
	SGT [redacted] 91W

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b(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES b(6)-2 AH
1205	Assumed care of pt [redacted] report given. Alert. PERRL
	@2mm. Lung sounds clear upper lobes bil. Diminished lower lobes
	bil. = rise & fall of chest bil. ⊕ Bowel sounds in all 4
	quads. Midline ABD incision = steri-strips CDI. LUQ
	small wound noted. No active bleeding or drainage noted.
	Skin w&d to touch. ⊕ radial & pedal pulses bil. HR 10?
	ST. Will cont. to monitor [redacted]
1240	Sit pt up @ bedside chair. SPO2 ↓ 89 O2 ↑ 40 6 L/Min
	NC. Will cont to monitor. SPO2 ↑ to 97%. Will
	cont to monitor [redacted]
1330	A line removed. A line Ⓛ wrist. Ⓛ AC IV s/s of infiltration
	or infiltration noted. Will cont. to monitor [redacted]
1530	SPO2 ↓ 88% Applied face mask. SPO2 @ 90%. Will cont.
	to monitor [redacted]
1600	New order received from Dr. [redacted] Chest PT
	q 2° & NT suction q 2° [redacted]
04 Oct 03 1800	received report from outgoing shift pt
	Alert SaO2 88 via face mask 10 l positioned
	pt upright 75 ↑° IS Aggressively. R 40
	even shallow ⊕ use abd muscles. ⊕ chest
	PT. productive yellowish thick sputum LS ↓ lower ⊕ Rhonchi

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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

[redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
# [redacted]			

DATE	NOTES
4Oct 03 0156	RT note: Pt awake. Pre tx HR 94, RR 28, SpO_2 93% on 50% venti mask but @ 5 LPM instead of 10. BBS CTA upper + diminished @ bases. Post UD Alb & Atro given via Venti mask. Post tx HR 97, RR 30, SpO_2 96% on 6L aerosol mask. Wife placed pt on 4L NC & bubble humidifier. IS done with good effort. —— Sgt [redacted] 91W2Q
4Oct 03 0544	Pt awake. Pre tx HR 97, RR 30, SpO_2 94% on 5L NC. BBS CTA upper + diminished lower. UD Alb given. Post tx HR 104, RR 38, SpO_2 95% on 6L aerosol. —— Sgt [redacted] 91W2Q
4Oct 1732	Pt awake Pre tx HR 103 RR 25 SpO2 93% 5L simple mask BBS CTA Lower lobes diminished UD Alb/Atro given on 6L. Post tx HR 102 RR 26 SpO2 95% BBS CTa diminished RLL Pt able to cough throughout tx —— Sgt [redacted] 91W2Q
2000	Pt pt Desat 89% Non rebreather placed on pt. placed on 10L ABG PH 7.422 PCO2 33.5 PO2 51 BE 1 HCO3 24 SaO2 89%. episode happened after LPN was moving pt around having him stand while changing sheets. Sgt [redacted] 91W2Q
2136	Pt awake HR 114 RR 33 SpO2 92% 15L Non rebreather BBS upper lobe CTA lower lobes Diminished UD Alb tx given Pt able to cough During tx Post tx HR 110 RR 47 SpO2 92% Pt very labored Pt still having difficulty maintaining Sat Doctor informed ——
2218 BG 5 Oct 03 0S/@0210	PH 7.565 PCO2 ~~28~~.5 PO2 51 BE 4 HCO3 2~~6~~ SO2 91% Pre tx HR 102, RR 33, SpO_2 96% on 15L NRB. UD Alb & Atro given BBS CTA c slight diminish at bases. Post tx HR 102 RR 40, SpO_2 94% on 8L aerosol mask. Pt SpO_2 95-96% 50% Venti mask. —— S[redacted] 91W2Q

P[redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES b(6)-2 A11
23 Sept 03	UD Alb tx given Pre tx HR 101 RR 25 SpO2 96% on 2L NC
1741	BBS Diminished
24 Sept 03 0813	Pre tx HR 111, RR-20, SpO2 96% on 6 L SM. UD Alb Neb given. BBS coarse + diminished. Post tx HR 118, RR 30, SpO2 94%. Nasal pharyngeal sx performed c good cough reflex & Pt coughed up 3cc thick yellow mucous. Sx ≈ 3cc clear fluid. Pt perform IS weakt. Will continue to monitor Sgt [redacted]
2 Oct 03	Pt. given UD Alb via inline @ 8L per P111-114 RR 29-16 O2SAT 95%-98% Pt. Sx for small amount of yellow sputum. SGT [redacted]
2 OCT 03	UD Alb/Atro given HR 102 RR 16 SpO2 98% BBS coarse
1821	pt Suctioned small amount of secretion Post tx HR 103 RR 16 SpO2 98% BBS Coarse
2 OCT	UD Alb tx via inline @ 6LPM HR 105 RR 16 SpO2 96% BS coarse
2130	pt Suctioned
3 Oct 03 0145	UD Alb/Atro given. HR 103, RR 23, SpO2 97% BS coarse but upon CTA, Sx minimal amount. Sgt [redacted]
	UD Alb/Atro Pre tx HR 100 RR 28 SpO2 94% BS Diminished
	Post tx HR 101 RR 23 SpO2 98% BS NO change pt
	instructed on IS Sgt [redacted] 711 25Y

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Pt [redacted] b(6)-1

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MEDICAL RECORD	PROGRESS NOTES

b(6)-2 A11

DATE	NOTES
5-OCT-03 0670	Assumed care of pt. Pt AOx3, can follow instructions. Movement and sensations x 4 extremities, pupils 3mm sluggish OU, venturi mask c̄ 8LPM O_2 @ 40%. Coarse (B) lung sounds noted, equal rise and fall of chest. Pt receiving NEB Tx and chest PT from Resp. Tech. Shows Tach s̄ ectopy, rate 100-110, +2 pulses throughout, (R) subclavian triple lumen, medial port clogged, (L) radial A-line, (L) AC saline lock patent, sites C/D/I, ABD round, midline steri-strips c/D/I, BS x 4 quadrants, NT, small bowel rectal Foley to gravity draining 2100 cc clear amber urine. [redacted]
5-OCT-03 0800	Pt c̄ OOB to chair, SpO_2 ↓, pt placed on NRB mask @ 15 LPM SpO_2 93%. Chest PT performed and pt coughed thick yellow secretions. Will monitor [redacted]
5-Oct-03 1200	2 PIV's started on pt. 18G (L) AC - patent, site C/D/I 18g (R) forearm - patent site C/D/I, Awaiting Dr. [redacted] to remove pt's central line. [redacted]
1815	Pt. seated in bed c̄ HOB @ 45°, NC [redacted] LPM, SaO_2 100%. VSS. ⊖ s/s pain / discomfort @ this time [redacted]
1930	Pupils ⊖ @ 2mm, PERRLA, pt. does not speak English, is able to follow simple commands + gestures. SR in ↑90's, ⊖ ectopy, ⊖ JVD, ⊕2 pulses throughout. 18G to (L) FA

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b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	b(6)-2 & 6
1930 (Cont)	has D5½ NS ē 20K @ 125 cc/hr. 18G to (R) AC by Heparin @ 20 cc/hr. (2) radial A-lines zeroed + flushed @ this time. NC @ 6LPM, S_aO_2 99%. @BS x4, noncontributive, last BM yesterday evening. ABD soft, round non-tender. Midline ABD incision ē steri-strips, CDT. 2x2 to (2) subclavians, CDT. Foley to gravity drain QS, dark yellow, clear urine. RT giving neb tx's + doing chest PT q4° — SPC [redacted]
2005	Lungs diminished in bases (B), wheezing heard (B), (E) rise + fall of the chest. (E) cough ē thick, clear secretions. — SPC [redacted]
2115	Pt. ↑ OOB ē assistance and to bedside chair. pt. appeared to have had a small BM @ an earlier time, cleaned up. Non-rebreather mask applied prior to pts. movement. S_aO_2 remained above 88% during movement. Returned to 92-94% while seated in the chair. Plan to leave pt. in chair until 2200. Will continue to monitor. — SPC [redacted]
2210	Pt. returned to bed ē (E) difficulty. S_aO_2 remained above 86%, when pt was settled back in bed, NC applied @ 6LPM ē S_aO_2 of 94-96%. — [redacted]
0010	Pt. c/o NC causing discomfort to his ears, 2x2's applied between tubing + ears, pt. gave a thumbs up for improvement. — [redacted]

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b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	RT note: Pre tx HR 95, RR 30, SPO_2 95% on 4L NC. UD Alb + Atro given via ~~Hfw~~ aerosol mask. Post tx HR-95, RR 36, SPO_2 92% on 4L NC. Pt refuse CPT. Pt verbal ~ language barrier; can not understand pt. Will continue to moniton b(6)-2 Sgt [redacted] 91W2Ø
Ø5OCT03 1326	Pt awake & sitting up HR 97 RR 30 SpO2 95% 4L NC BBS CTA UD Alb tx given HR 101 RR 29 SpO2 95% BBS NO change Sgt [redacted] 91W2Ø
5OCT 1743	Pt awake HR 92 RR 22 SpO2 99% on 6L NC BBS CTA UD Alb/Atro nebs given Post tx BBS CTA HR 90 RR 32 SpO2 98% 6L NC Sgt [redacted] 91W2Ø
5OCT 03 2246	Pt awake Pre Tx HR 97 RR 18 SpO2 94% 6L NC BBS clear b(6)-2 UD Alb tx given Post tx HR 97 SpO2 98% BBS clear Sgt [redacted] 91W2Ø
6Oct Ø3 Ø2ØØ	Pre tx HR 91, RR 25, SPO_2 97% on 4L NC. BBS CTA. UD Alb & Atro b(6)-2 given via aerosol mask. Post tx HR 93, RR 30, SPO2 97 on 4L NC Sgt [redacted]
6Oct Ø3 Ø615	Pre tx HR 99, RR 29, SPO_2 95 on 4L NC, UD Alb neb given Pt cough up thick mucous & green. Post tx HR 97, RR 35, SPO_2 96 on 4L NC Sgt [redacted] 91W2Ø b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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[redacted] b(2)-2

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b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
060CT03 2137	Continued: noted. O_2 Sat 96-99% on 1L O_2 via NC. Will wean as tolerated. Pt continues on QH neb tx c Chest PT, tolerating well. RR↑20's HR 80-90's, RRR. S_1+S_2 audible. Cap Refill <3sec to all extremities. Radial+Pedal pulses strong+equal to palpation bilaterally. Pt has 18G IV to (R) forearm infusing D5½NS c 20mEq KCL @ 125cc/hr. Pt has (L) radial A-line, CDI; ~~no~~ signs of redness or infiltration to either site. BS active x4 Quadrants. Non-soft, Non-tender, Non-distended. Pt has ~~sutures~~ MEF steri-strips to midline abdomen, CDI, open to air. Pt has foley to gravity draining clear yellow urine >30cc/hr. Complete ROM to all extremities. OOBTC c assistance due to stiffness. Pt has productive cough. Will continue to monitor for Δ's. ——— SPC [redacted] 91WM6
2200	Pt O_2 ↓ to 0.5L via NC. O_2 Sat 97%. Will continue to wean as tol. — SPC Fowler Megan 91WM6
2220	Pt OOBTC c minimal assistance. Pt remains on 0.5L O_2 via NC. O_2 Sat ↓ to 90-93% while moving to chair. Pt taking very quick, shallow breaths. Encouraged to take deep breaths + use IS. O_2 Sat ↑ to 95%. Will continue to monitor for Δ's. ——— SPC [redacted] 91WM6
2317	Pt coughing up a large amt of yellow/green sputum. O_2 Sat ↓ 88%, O_2 ↑ to 2L, Sats 90%, ↑ 4L O_2 Sat 93-95%. Pt continuing to take short shallow breathing. Explained to pt need to take deep breaths via interpreter c no effect. Pt O_2 Sat ↑ to 96% + stable when pt not coughing a lot or actively thinking about breathing. Will return to bed @ 0001 + continue to wean O_2. Will continue to monitor for Δ's. ——— SPC [redacted] 91WM6
070CT 2400	assumed care received report from outgoing nurse. Pt OOB x 1 hr. tolerated well. VSS NAD A+Ox3 color good S_pO_2 @ 98% @ .5l NC. will cont OOB Monitor IS encouraged. SPC [redacted] 91WM6

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
6OCT03 0530	Pt. bumped down to O2 @ 4LPM via NC. Will monitor effects. SaO2 currently 96% —— SPC [redacted]
6 Oct 03 0030	Assumed care of pt. Pt in bed A&Ox3, NAD, HOB 40°. VS 144/78 (TAV), 98.3 (ax), 107, 12, 94% SaO2 on 4LPM NC. (B) coarse lung sounds more ↓ on (R) base, (+) productive cough. Equal rise and fall of chest, ST rate 100-110, + 2 pulses throughout. S1 S2 present, (L) AC saline lock - site C/D/I, patent, (R) forearm saline lock C/D/I, patent, Abd round, soft, ND, NT, [illegible] incision intact, BS x 4 quadrants, foley to gravity draining clear amber urine >100cc/hr. [redacted]
6-Oct-03 0730	Pt ate 30% of breakfast. [redacted]
6-Oct-03 0900	Pt ↑ OOB to chair, Maintains SaO2 [illegible]% on 4L O2 via NC, Continues cough produces thick yellow secretions, Foley to gravity drains clear yellow urine, Will monitor [redacted]
6-Oct-03 1600	Pt ↑ OOB to chair, SaO2 remains @ 93% on 4LPM via NC. Pt coughs thick clear/yellow mucous. IS in use. Lungs (R) base still ↓ compared to (L) base. Pt A&Ox3, (0) distress. [redacted]
06OCT03 2137	Assumed care of pt @ 1800. VSS, afebrile. Alert + Oriented. PERRL, 3mm. Mucous membranes moist. Tolerating small amts of regular diet. Lung sounds clear bilateral c̄ diminished bases c̄ R>L. RR equal + unlabored. No use of accessory muscles → Continued

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
			b(6)-2 A11

DATE	NOTES
7 Oct 03	O2 off. SPO2 @ 97%. CT PT done. IS used approx @ 10 X5 c
1000	2nd ball raised & 3rd raised @ X5. Lung sounds CTA bil BS
	(+) in all 4 quads. Midline ABD incision c steri-strip C/D/I. A line
	DSG (L) wrist area C/D/I. IV 18G (L) AC & (R) FA WNL. SPO2 @ 96%
	p O2 turned off. Will cont. to monitor — [redacted]
1100	IS used approx. 15 X5 c 2nd ball raised c 3rd ball
	raised @ X5. SPO2 95%. R 30. Will cont. to monitor —
	[redacted]
1200	Chest PT done. IS used approx 15 X5 c 2nd ball raised
	& @ X5 3rd ball raised. SPO2 @ 96%. R 21. Will cont to
	monitor — [redacted]
1300	IS used approx 15 X5 c 2nd ball raised & @ X5 3rd
	ball raised. SPO2 @ 96%. Will cont. to monitor [redacted]
1400	Lung sounds CTA bil. BS (+) in all 4 quads. SPO2 @ 98%
	Pt assisted ↑ to chair. SPO2 @ 98%. VSS. IV 18G (R) FA D5NS
	@ 125 cc/hr via (R) FA 18G patent & s/s of infection. 18G (L)
	AC s/s of infection. Flushes well. Chest PT done. IS used
	@ 12 X5 c 2nd ball raised & 3rd raised @ X5. Will cont.
	to monitor — [redacted]
1500	IS used approx 12 X5 c 2nd ball raised & 3rd raised
	@ X5. SPO2 @ 97%. Will cont. to monitor — [redacted]
1600	Chest PT done. IS used approx 12-15 X5 c 2nd ball raised
	& 3rd raised @ X5. SPO2 @ 97%. Will cont. to monitor [redacted]
	Pt assisted back to bed — [redacted]
1705	Report given to Spc [redacted] — [redacted]
1730	Transferred pt to ICW 2 per litter. — [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
06 Oct 03	2430 - pt back in bed HOB ↑ position on back RA c assist NAD VSS b(6)-2 [redacted] will cont to monitor [redacted]
0000	Assumed care of pt p night shift, report given by [redacted]
1 Oct 03	LR. See assessment flow sheet. Will cont. to monitor. [redacted]
0630	Pt assisted to chair. Chest PT done. IS used approx @ 10 x 5 c 2nd ball raised & @ x 5 3rd ball raised. Will cont. to monitor [redacted]
0715	IS used approx. @ 10 x 5 c and ball raised [redacted] x 5 3rd ball raised. Pt sitting up in chair. Will cont. to monitor SpO2 @ 91%. R 33. [redacted]
0820	CT PT done. IS used approx @ 10 x 5 c 2nd ball raised & 3rd raised @ x 5. Will cont. to monitor, SpO2 @ 96% R 36. [redacted]
0850	Assisted pt back to bed. [redacted]
0910	A line D/C'd. Bulb intact. Pressure applied for 5 min. Applied 4x4's & secured c tape. Will cont. to monitor. O2 off. SpO2 @ 96% before O2 turned off. SpO2 @ 90%. Will cont. to monitor [redacted]
0955	SpO2 + 90%. O2 @ .5 L/min per NC. Reapplied. SpO2 [redacted]% Will cont. to monitor [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI [redacted] b(6)-2

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[redacted]

b(6)-4

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b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
8 Oct 03 0600	Pre tx HR 80, SPO_2 93% on RA. UD Alb neb given. R cough throughout tx. BBS CTA. Post tx RR 20-26, SPO_2 96, HR 92 IS done — Sgt [redacted] b(6)-2 QWD
9 Oct 03 0020	Pre tx HR 96, RR 20, SPO_2 96% on RA. UD Alb neb given. BBS CTA —. Post tx HR 92, RR 28, SPO_2 96%. — Sgt [redacted]
9 Oct 03 0515	Pre tx HR 90 RR 22, SPO_2 93% on RA UD Alb neb given. BBS slight coarse clears c cough. Post tx. HR 94, RR 30, SPO_2 93-97% — Sgt [redacted] b(6)-2

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[redacted] b(2)-2

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b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6Oct03 1747	Pt awake Pre tx hr 91 RR 24 SpO2 98% BBS CTA UD Alb tx given pt cough throughout tx HR 96 RR 22 SpO2 98% b(6)-2 Sgt [redacted] 91W20
6oct 0134	Pt awake + alert Pre tx HR 94 RR 28 SpO2 97% on 1 LNC BBS CTA Diminshed CPT [redacted] pt able to cough During tx UD Alb/Atro given Post tx HR 93 SpO2 97% on 1 LNC RR 13 BBS CTA b(6)-2 Sgt [redacted] 91W20
7 Oct 0330	Pt awake. Pre tx HR 92, RR 22, SPO2 96 on 0.5 L NC. BBS CTA. No UD Alb & Atro given. Post tx HR 98 RR 30 SPO2 96 on 0.5 L NC. b(6)-2 Sgt [redacted] 91W20
7 Oct 03 0600	Pt awake. Pre tx HR 98, RR 20, SPO2 95 on 0.5 L NC. BBS CTA. UD Alb given via HHN c mouthpiece. Pt deep breaths every 4th-5th breaths. Post HR 92, RR 28, SPO2 96% on 0.5 L NC. +Cough up thick secretions. +IS b(6)-2 Sgt [redacted] 91W20
7Oct 03 1820	Pt awake Pre tx HR 92 RR 20 SpO2 94% on RA BBS CTA b(6)-2 UD Alb tx given Pt coughed throughout tx. Post tx HR 96 RR 22 SpO2 94% BBS no change Sgt [redacted] 91W20
8 Oct 03 0020	Pre tx HR 90, RR 22, SPO2 95% on RA. BBS coarse but CTA c cough. UD Alb tx given Post tx HR 93 RR 26 SpO2 94%. Sgt [redacted] 91W20 b(6)-2

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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

b(6)-4

Pt [redacted] ICW 2

[redacted]

Alb Q6 X 48hrs

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
09OCT03	VSS Alert & Oriented c/o lower abd pain
0850	and c/o not able to void. Lower abd
	distended. Dribbling urine from penis
	upon standing. Foley cath inserted
	1300 cc of tea colored urine obtain
	Foley left in place. Lungs with scattered
	rhonchi in upper lobes. Diminished lung
	sounds to both lower lobes. Assisted
	pt OOB to chair and instructed on
	proper use of Incentive Spirometer.
	Used properly @ 900cc/sec. Has non productive
	Cough. Midline abd. incision with edges
	well approximated and steri strips intact
	Peripheral pulses +2. Will continue care
	as planned —— [redacted]
9OCT03	VSS. AO. Encouraged to use IS q1° for 10 times.
1944	Understood LS coarse in RLL and clear in other
	regions. Abdominal wound CDI and [redacted]
	Resting comfortably in bed. ——
10OCT03	(1055) Assumed care of pt @ 0600 p report from night
	shift. Pt alert, speaking Arabic VSS. Ø c/o pain. Lung
	sounds ↓ in lower lobes. ØSOB or resp. distress noted.
	Pt amb in hallway s̄ assist. Tol. well. Foley draining:
	quantity sufficient clear yellow urine. IVF infusing
	into IV in Ⓛ forearm s̄ difficulty. Ø s/sx infection/
	infiltration. Steri strips to midline abd incision CDI.
	Tol. small amount of reg. diet. 2 point restraints in

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
~~0800~~ 0803	(1635) Pt tx to ward from ICU2 in stable cond via WC. Lungs CTA(B). Decreased breath sounds in (B) V lobes. @ SOB or resp. distress noted. IVF infusing via dial-a-flow into IV in @ dc S S/Sx infection/infiltration. SL in @ ac dlcd d/t infiltration. - catheter inact. Voiding S difficulty. Tol po well. 2-point restraints in place S S/Sx complications. Will cont. to monitor. b(6)-2 [redacted] (W/M)
80ct03	1845 = VSS, O2 sats @ 96% RA post-albuterol tx. Lung sounds course & diminished (B) V lobes pre-tx, sound more clear (B) V lobes post-tx, reinforced IS 5x/hr while awake - pt. does IS exercises S difficulty. Steri strips to midline abdominal incision - healing - CDI. UOP adequate via urinal CBS. Assist OOB to ambulate in hall x2 restraints while in bed @ Skin breakdown noted, Continue to monitor for acute Δ's b(6)-2 [redacted] lt/A
~~80ct03 @ 2300 = IV RES~~	
80ct03 @ 2300	= IV restarted to (L) FA, D/c'd IV to (R) FA intact. b(6)-2 [redacted] lt/A

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO. TCWH4

#[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

Oct 03 @ 0345 - pt. found c IV pulled out & IVF's leaking on floor, instructed pt (via translator) to not pull out IV's, IV restarted to (L) hand running D5NS c 20meq KCl, x2 arm restraints in place, x2 curley wrapped to wrists tied to sides of bed to prevent pulling at lines ⊖ skin breakdown, ⊖ circulatory compromise. [redacted]

14 Oct 03 - 0700 - Assumed care of pt. A+O x 3. VSS. PIV infusing D5NS @ 125 cc/hr @ hand. patent site c/d/I. Abdominal incision open to air secured c steri strips healing well. ⊖ s/s of infection. Decub to sacrum duoderm applied. Q2 x position change encouraged pt. favors supine position rolled covers to support side position. Foley to gravity. Amber urine. Qs Encouraged PO fluid. Will cont to monitor [redacted]

14 Oct 03 VSS. AO. Reinforced to pt. to discontinue pulling out 2145 pts IVAB by himself and pt. understood & complied. ⊖ c/o pain @ this time. Abdominal incision CDI c steri strips @ base intact. ⊖ s/s infection. LSCTAB. BS @ x4. Voiding light amber urine quantity sufficient @ purses. [redacted] RN

15 Oct 03 @ 0700 - Assumed care of pt. A+O care given ambulated to shower c difficulty. c/o SOB while in shower O2 sat 96% RA. Encouraged deep breathing lungs clear non productive cough. Abdominal incision healed well ⊖ s/s of infection remains afebrile. Breakdown to sacral/buttocks area open to air pt positioned on stomach to prevent further breakdown Q2° position change. PIV @ hand intact D5NS c 20meq KCl @ 125 cc/hr ⊖ c/o pain or discomfort @ this time. Will cont to monitor [redacted]

(1245) I concur c above assessment. [redacted]

STANDARD FORM 509 (REV. 6/1999) BACK
USAPA V1.00

b(6)-2
All

MEDCOM - 19583

b(6)-2 A11

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30 Oct 03 0933	Received pt resting in bed, VSS, tol RD poss appetite for breakfast this am. Amb in hallway w/ walker, and to BR. Am care provided, LCTA, duoderm placed on sacral decub stage II. Foley patent, to gravity drainage clr amber urine, medium. Yellow. Midline abd incision CTA w/ steri strips intact. HOH, enc is, IV to (R) fa patent & intact. & indications of resp distress nte. Restraints per SOP protocol, & breakdown noted c restraint points. Will continue to monitor pt [redacted]
30 Oct 03 1930	= VSS, 0/10 pain, O2 sats [redacted], & S/S resp distress, LCTAB, OOB & ambulates c walker PRN c difficulty, steri strips to midline abdominal wound CDI, Duoderm to sacral wound CDI, IV to (R) FA running D5NSc 20meq KCl c difficulty, Foley to gravity draining amber colored urine, x2 restraints when in bed c skin breakdown noted, will continue to monitor. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

EPW [redacted]

REGISTER NO. | WARD NO.

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1000	- Pt 8 hour post Foley catheter removal has not voided orders to in and out cath if greater than 500 leave in place urine output 400 cc. Given pt. inability to urinate and mental state Foley cath was left to gravity dark yellow urine. will cont to monitor [redacted] b(6)-2 grimace.
(1315)	I concur c above assessment. [redacted] WA
(1940)	Rt awake, VSS, ϕ complaints, amb x 1 in hallway. Foley to gravity draining dark amber urine. Q2 turns. Sacral decub c W-D. drsg S/S. LOTAB, HRRR, ⊕BS x4. ⊕ pedal pulses, O2 sats 95-97% RA. D5NS c 20 meq KCL cont. 2 pt restraints on S compromise to skin or circulation. Will monitor [redacted] 911 WMC. b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Oct 03 0700	-Assumed care of pt. A+O x3. VSS. Ø c/o pain or discomfort @ this time. Lungs CTA HRRR. Active BS decreased appetite. Tolerating PO. Foley to gravity dark amber urine. QS. PIV @ ACM D5NS c 20meq KCl. Encourage Q2° position change breakdown to sacral area. stage II open to air. Position on stomach @ this time AM care given bed bath. Will cont to monitor [redacted] b(6)-2 (530) I concur c above assessment. [redacted]
(2015)	Pt awake, VSS, Ø complaints @ this time. LCTAB, HRRR @ RA x4, amb. in hallway c walker x 15 min. foley draining dark yellow urine. Q2° turns. ~~to~~ Sacral breakdown noted (OTA) stage II. D5NS c 20 meq KCl infusing @ this time. to (D) FA. IS encouraged. 2 pt restraints on 5 compromise to skin/circulation will monitor [redacted] b(6)-2 9 IWM6.
(0200)	foley d/c'd. due to void in 8° or less. (1000) 18 OCT 03 [redacted] b(6)-2 9 IWM6
18 OCT 03 0700	-Assumed care of pt. A+O x3. VSS Ø c/o pain or discomfort @ this time. Continue Q2h position change breakdown to sacral area stage II healing open to air. lungs clear O2 sats 96% RA non productive cough. HRRR. Active B.S. Tolerates PO Ensure c meals. ~~Voiding QS~~ Due to void 8° post foley removal 1000 this am. Will cont to monitor [redacted] b(6)-2

[redacted] b(6)-4

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15OCT03 2100	VSS. AO. Pt. translated that he was depressed for beig here. Placed upright in bed. ASC/AB. ↓ diminished bases. Encouraged to dep breathe. IV D5NS ≈ 20K @ 125 cc/hr. OOB to ambulate ≈ use of walker for 15 min ≈ minimal assistance. Abdominal incision CDI. b(6)-2 [redacted]
16OCT03@0700	Assumed care of pt. A&O x 3. Stage II decubitus ulcer x 2 to buttocks bilaterally. Duoderm applied ≈ AM care. Pt. ambulated to BR ≈ walker and assistance. Pt. has foley to gravity, amber urine. Pt. has IV to (R) FA, D5~~4~~NS @ 125 cc/°. All other assessments WNL. EPW restraint protocol used. (R) skin breakdown noted. [redacted]
16OCT03@1745	Pt. 's urinal emptied, dark amber urine, 750 cc. [redacted]
16OCT03 2335	VSS. AO. Sparky awoken after to himself. ASC/AB. Abdominal incision CDI. BS (+) x 4. IV removed to (R) arm - HL compel placed to sacral, stage II decubitus sacral ulcer. (+) pulses in all extremity. Mentation still questional. Voiding light amber urine @ 85 ≈ FTG. Skin intact to all restraint extremities. Ambulated BR with for meal. IV D5NS ≈ 20K @ 125 cc/hr. [redacted] b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.

WARD NO. CW#1

b(6)-4

[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Oct 03	Transfer Summary Iraqi Prison Hospital
	Admit Date 19 Sep 03
	DC Date 19 Oct 03
	Dx 1) GSW from Right Flank 3) Acinetobacter Bilateral
	2) Fractured Sacroiliac joint Lower lobar pneum
	Procedure - Xlap 4) [illegible] resp [illegible]
	Hospital Course - 40 y/o Iraqi sustained GSW to (R) Flank
	Hemodynamically unstable taken to OR Xlap
	Finding of hemoperitoneum. No vascular or bowel injury
	Bleeding from shattered [illegible] for sacroiliac region.
	Post op [illegible] developed Acinetobacter
	Sepsis from Bilateral lower lobe pneum. Treated
	14 day course of Primaxin + Tobramycin with good
	response. Extubated o/a 5 October. Completed
	Antibiotics. No further fever. Currently needs [illegible]
	rehab [illegible] to go to EPW camp.
	MEDS Percocet 1-2 PO q 6° prn pain.
	[redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

[redacted]
b(6)-4

NSN 7540-00-634-4178

600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19SEP03	OP Note
0400	indication Surgical Ald with hypotension
	procedure exLAP exploration of retroperitoneum
	② Medial Visceral Rotation
	surgeons [redacted]
	Anesth GEMA Bently/Lyons
	Fluids - 3000 cc LR
	1200 NS blw-2 All
	1u PRBC
	Findings. ① Small Amt of Hemoperitoneum. ② Large ③ Retroperitoneal Hematoma. NO Major Vascular or Urologic injury in Retro. Bullet tract through Illeac wing/sacrum/subcutaneous paraspinous muscles; surgical placed Drs — placed comp noted
	Dispo extubated to ICU in good cond.
	[redacted]

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 19589

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Oct 03	Pt transferred to ward last night. Remains off O2. Looks good. Will DC foley tomorrow. Needs to complete additional week of Abx.

[redacted]

b(6)-2

b(2)-2 NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED [redacted]

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 0120 | TIME 0120

TRANSPORTATION TO FACILITY

SEX: M

AGE: 39 (40)

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: ~~[redacted]~~ 10mg DIAZEPAM

ALLERGIES: ϕ

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW ABD ⊕ smoking

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 0120 b(6)-2

INITIALS: [redacted]

VITAL SIGNS

TIME	0125	0130	0135	0140
BP	74/31	60/36	60/39 manual	54/25
PULSE	96	96	98	96
RESP		20		
TEMP				
WT	160			

LAB ORDERS

☐ CBC/DIFF	☐ ABG	☐ PT/PTT	☐ BHCG/URINE/BLOOD/QUANT
☐ URINE C&S	☐ UA MSCC/CATH		☐ CHEM:
☐ BLOOD C&S X			

X-RAY ORDERS

☐ CXR PA & LAT/PORTABLE	☐ C-SPINE
☐ ACUTE ABDOMEN	☐ LS SPINE
☐ SINUS	☐ HEAD CT
☐ ANKLE R/L	

ORDERS

☒ PULSE OX 100 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0130	IV (D) AC NS				

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION

(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

EFW [redacted] b(6)-4

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC: WBC; H/H; PLT — SMAC — PT — APTT — BHCG — ETOH — GLU

ABG/PULSE OX: SUP O2 — PH — PO2 — PCO2 — SAT — OTHER

UA: DIP — MICRO

RADIOLOGY — Check if read by radiologist ☐ — RESULTS

EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL

#1 of 3. HRRR - SR on monitor. Abd distended

0130 2 Large bore IV started - blood drawn

8.5 F Femoral line started

GSW to Abd

0140 - TO OR

COI

DIAGNOSIS

ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
	PROVIDER SIGNATURE AND STAMP
	CODES

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

b(6) - 4

[redacted]

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

(5)(2)-2 Inl

[redacted] ICU #2

VENTILATOR FLOW SHEET

8.0 ETT
22cm @ teeth
Pt # [redacted] b(6)-4

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
1530	26Sept03	Simv	14	800	100	5	29	14	140	98	123/76							R went into resp arrest [redacted]
1654	26Sept	Simv	14	800	100	10	38	16	124	95	90/58							BS clear
26 Sept	2157	Simv	14	800	80	10	30	14	120	99	94/59							[redacted]
27 Sept	0020	SIMV	12	800	60	10	36	12	112	98	117/65	7.48	30.5	96	-1	23	98	[redacted] faint wheezing Albneb
	0145	SIMV	12	800	55	10	33	12	108	98	110/60							
	0610	SIMV	12	800	50	10	36	12	105	97	123/58	7.43	39	137	2	26	99	
	0800	Simv	12	800	50%	10	32	12	113	98	124/67							
	1006	Simv	12	800	50	10	27	12	120	97	129/61							
	1400	Simv	12	800	50	10	32	12	121	97	161/64							
	1527	Simv	16	800	60	10	29	18	111	96	125/61							Sx [redacted]
	1814	Simv	16	800	60	10	40	19	116	97	138/60							
	1934	Simv	16	800	70	10	34	16	115	95	118/56							Sx Albneb [redacted]
	0020	SIMV	16	800	60	10	34	17	106	95	120/53							
	0230	SIMV	16	800	35	10	29	16	113	97	134/58							Sx - Alb neb
	0450	SIMV	16	800	55	10	41	17	110	95	128/60							Sx
	0620	SIMV	16	800	50	10	50	17	116	98	134/71							[redacted] Alb neb [redacted]
	0800	Simv	16	800	50	10	28	16	108	97	131/58							
	1000	Simv	16	800	50	10	31	16	103	96	106/58							
	1200	Simv	16	800	50	10	30	16	114	100	138/62							
	1400	Simv	16	800	80	10	34	21	115	98	[illegible]/60							Sx NEB [redacted]
	1800	Simv	16	800	50	5	33	16	114	98	122/72							
	1942	Simv	16	800	50	5	37	19	110	99	119/65							
	2207	Simv	16	800	50	5	37	29	119	97	147/66							[redacted] case Alb 4x [redacted]
	0015	SIMV	16	800	50	5	34	17	103	98	115/64							nurse
	0330	SIMV	16	800	50	5	32	17	114	98	111/60							
	0540	SIMV	16	800	50	5	30	20	112	95	115/63							Alb + Atro [redacted]
	0700	Simv	16	800	50	5	35	16	111	97	108/59							
	1000	Simv	16	800	50	5	37	16	111	98	121/68							
	1525	Simv	16	800	50	10	36	16	127	97	123/72							[redacted]
	1818	Simv	16	800	60	10	38	17	123	94	106/58							OH
	1942	Simv	16	800	60	10	36	17	126	96	92/54							Alb/Atr BS ↓ [redacted]
	2149	Simv	16	800	55	10	37	17	112	96	84/53							[redacted]
	0020	SIMV	16	800	50	10	39	23	117	96	125/78							Alb 4x Sx [redacted]
	0155	SIMV	16	800	50	10	36	16	113	99	114/71							Alb + Atro [redacted]
	0359	SIMV	16	800	50	10	47	17	100	100	108/63							Alb neb [redacted]

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.

1. AGE: 3 o
HEIGHT:
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): ?

3. PREVIOUS SURGERY [ ] NO [ ] YES (type): ?

4. PROPOSED SURGICAL PROCEDURE:
Exploratory Lap.

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: ? Implants: ? Medications: ?
Jewelry removed: yes/no Family waiting: yes/no
Emergency

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)

[redacted] PW
b(6) - 4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. Potential impairment of mobility due to sedation; pain; injury E.2 Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. Disminished visual perception due to being injury; sedation; F.2. Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from [redacted] side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] blw-2 19 Sept 03 DATE

11. POSTOPERATIVE EVALUATION:

able to move - aware. able to respond to verbal stimuli.

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)

[redacted] MA

DATE: 19 Sept 03 TIME: 01

13. PREOPERTIVE EVALUATION PREPARED [redacted]

DATE: 19 Sept 03 TIME: 0335

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY Anesthesia
2. PATIENT IDENTIFICATION RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] (Emergency)
3. DATE 19 Sept 03 TIME PATIENT ARRIVED IN SUITE 0140
4. PATIENT IN ROOM TIME 0140 b(6)-2 NUMBER TRAUMA OR

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☑ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: Pt able to move

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR INT.	

7. POSITION AND POSITIONAL AIDS (Specify)

Pt placed on OR bed arms on arm board 90°

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Strapped strap above Knees and PPP.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine/Betadine b(6)-2

SITE: Neck to

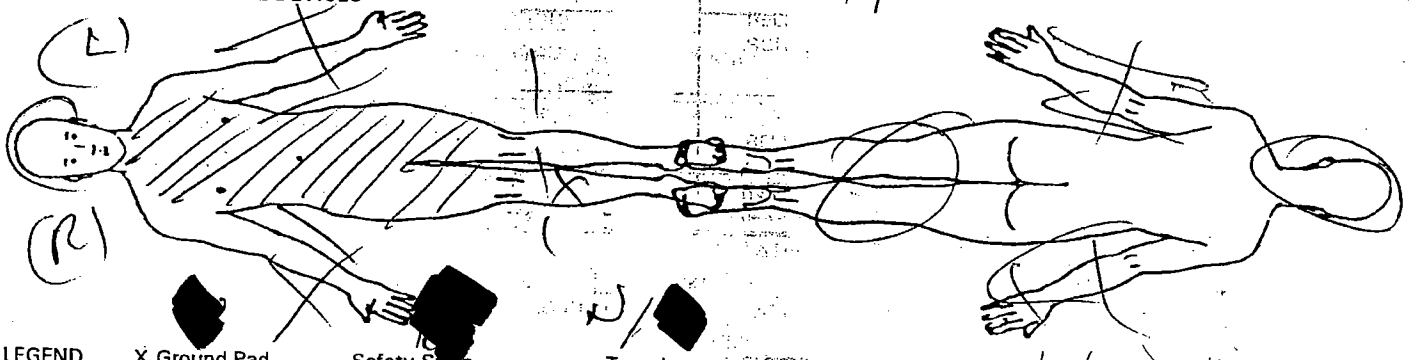
SITE: Knees

BY WHOM:

BY WHOM: [redacted]

COMMENTS: Pooling of Solution with

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	C	C	C
Needle Sharp	☒ Yes ☐ No	C	C	C
Instrument	☒ Yes ☐ No	C	C	C
Other	☐ Yes ☒ No			

SCRUB [redacted]

CIRCULATOR [redacted]

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

[redacted] EPW

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valley Lab 40 TRAUMA Room

GROUND PAD: BRAND Valley Lab Pad

LOT NO: 48936 2005/03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 19596

13. PROSTHESIS, IMPLANTS ☐ YES ☐ NO IF YES NAME: ID NUMBER; FACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO; TYPE(S): Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] b(6)-2

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* 4x8 Steri-Strips Tape Benzoid

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	16Fr Foley	400cc Hemovac	
SITE	Bladder (Cont)	Abdomen (R flank)	

19. ADDITIONAL INFORMATION

S: [redacted]

A: [redacted]

Brief OR clear, dry intact, pre-post op

20. OPERATION(S) PERFORMED

Exploratory lap

21. PATIENT TRANSFERRED TO SICU TIME 0335 METHOD Cart

[redacted] SIGNATURE

REVERSE OF DA FORM 5179-1, OCT 87

b(6)-2

MEDCOM - 19597

USAPA V1.00

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 4

DATE: 8 Oct 03

SECTION I - PATIENT ASSESSMENT

PATIENT ACUITY LEVEL: III | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200																	
BP ARTERIAL LINE																		
BP CUFF	102/60																	
TEMPERATURE	98.0																	
PULSE	89																	
RESPIRATORY RATE	16																	
OXYGEN (L/%)	0																	
PULSE OXIMETER	97%																	
O2 METHOD	RA																	

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1000	1200																
PAIN INTENSITY (10 / 5 / 0)	0	0																
MED ADMINISTERED (Y/N)	N	NA																
RELIEF ACCEPTABLE (Y/N)	N/A																	

SPECIAL NEEDS

TIME:	1000																	
*Skin breakdown prevention	N/A																	
*Falls prevention protocol																		
*Restraint protocol																		
*Seizure precautions																		
*Isolation precautions																		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

OTHER

TIME:	1000	1200																
FINGER STICK GLUCOSE	N/A	NA																
INSULIN (Y/N)																		

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

DIAGNOSIS: S/P GSW abd

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

MEDCOM FORM 688-R (TEST) (MCHO) MAR 00 PREVIOUS EDITIONS ARE OBSOLETE Page 1 of 4 pages MS V1.0r

S[illegible]N II - PATIENT ASSESSMENT - REVIEW OF S[illegible]AS

DIRECTIONS: A check ✓ in the small b[illegible]ficates patient assessment criteria have been m[illegible] If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1000 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. **NEUROLOGICAL:** Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	☐	☐
2. **CARDIOVASCULAR:** Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	☐	☐
3. **PULMONARY:** Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓	☐	☐
4. **G.I.:** Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	☐	☐
5. **G.U.:** Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Foley D/C'd DTV@ 1800	☐	☐
6. **MUSCULOSKELETAL:** Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	✓	☐	☐
7. **SKIN:** Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Midline ABD incision c steri-strips OTA	☐	☐
8. **PAIN:** No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	✓	☐	☐
9. **PSYCHOSOCIAL:** Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

	TIME: 1000 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q 8 hr:	PRN		
IV site care provided:	assessed		
IV tubing changed:			
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	ⓐAC / OK		
IV Site #2:			
Comments:	D5NS c 20 Kcl @100cc/hr.		

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE:	TIME:	1					
COLOR		N/A					
CAPILLARY REFILL		↓					
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE		✓					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME:	D		
SAFETY	ID visible/legible	[redacted]		
	Orient to environment prn			
	Side rails (2/4) up	N/A		
	Bed position low			
	Call light within reach			
OTHER	Review & post lab results			
	Notify MD abnormal labs			
	Incontinent urine/stool			
	Linen change prn			
	Turn/reposition q2h			
	ROM q2h if immobile			
	Antiembolic hose	✓		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE:	TYPE:
PERCENT CONSUMED: 0%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT: 1	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT:	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT:

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT:	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EBN [redacted] b(6)-4	[redacted]	[redacted] b(6)-2	D

N RECORD - PATIENT ACTIVITIES I HEET

For use of this form, see MEDCOM Circular 40-

SECTION I - PATIENT ASSESSMENT

PATIENT ACUITY LEVEL : | POST-OP DAY: | HOSPITAL DAY:

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT: ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Time 1740 To ICU2 From ICU2 Anesthesia (Specify):

Total ER/RR/PACU time Physician B/P P R T

Procedure/Diagnosis Neurovascular checks

LOC Tubes

Dressing/cast Steristrips Abd inc Voided ☐ No ☐ Yes Amount:

Intake (IV, po) Output (EBL, other)

Medication

Other Received By

Report From

VITAL SIGNS

TIME:	1740	2000	1200	0400												
BP ARTERIAL LINE																
BP CUFF	118/64	100/60	100/66	90/60												
TEMPERATURE	97.1	97.8	97.8	990												
PULSE	94	97	88	97												
RESPIRATORY RATE	18	18	18	20												
OXYGEN (L/%)	0															
PULSE OXIMETER	96%	94%	94%	94%												
O2 METHOD	RA	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula MT = Mist tent NR = Non rebreather PR = Partial rebreather FM = Face mask A = Aerosol VM = Venturi mask TC = Trach collar

PAIN

TIME:	1740	2000	0400													
PAIN INTENSITY (10 / 5 / 0)																
MED ADMINISTERED (Y/N)	* N															
RELIEF ACCEPTABLE (Y/N)	N/A															

OTHER

TIME:																
FINGER STICK GLUCOSE																
INSULIN (Y/N)																

SPECIAL NEEDS

TIME:

- *Skin breakdown prevention
- *Falls prevention protocol
- *Restraint protocol
- *Seizure precautions
- *Isolation precautions

YESTERDAY'S WEIGHT:

TODAY'S WEIGHT:

WEIGHT CHANGE:

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW [redacted] b(a)-4

DIAGNOSIS: SP GSW Abd

DRG: ADMISSION DATE:

LOS: EXPECTED RELEASE:

CASE MANAGER:

PRIMARY CARE MANAGER:

ISOLATION REQUIRED (Specify):

II - PATIENT ASSESSMENT - REVIEW OF S

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1740 INITIA[redacted]	TIME: 1930 INITIAL[redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☒	☑ b(6)-2	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☒	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐ non-productive cough	☐ nonproductive cough Pneb tx	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☐ Steri-strips to Abd.	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Foley c clear amber urine	☐ Foley c clear/amber urine qs	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Activity amb c assistance Pt transferred by litter	☐ Amb c assist TID Pt c weakness to (B) LE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Abd incision c steri-strips no drainage	☐ abd incision midline c steri-strips CDI no drainage	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☒	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☒ b(6)-2	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

	TIME: 1740 INITIALS: [redacted]	TIME: 1930 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 6 hr:			
IV site care provided:	Assess/flush		
IV tubing changed:			
IV Site #1:	(L) AC — OK	(L) AC — OK	
IV Site #2:	(R) FA — OK	(R) FA — OK	
Comments:		DSNS @ 100° to (L) AC	

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

SECTION III - PATIENT INTERVENTIONS & TEA

SITE:	TIME:					
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY	TIME:	1740	1930
	ID band visible/legible	[redacted]	
	Orient to environment prn		NA
	Side rails (2/4) up		
	Bed position low		
	Call light within reach		

OTHER			
	Review & post lab results		
	Notify MD abnormal labs		
	Incontinent urine/stool		
	Linen change prn		
	Turn/reposition q2h		
	ROM q2h if immobile		
	Antiembolic hose		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 0
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: well
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT: 1	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME:	INITIALS:	CONTENT:	
1740	[redacted]	- CALL FOR ASSIST - ~~AAA~~ WARD ORIENTATION	☒ Patient/Family Verbalizes Understanding
1930	[redacted]	- Call for assist - pain management	☒ Patient/Family Verbalizes Understanding
			☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

EPW [redacted] b(6)-4

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	[redacted] LVN/RN	18-06

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1940	Abd ML inc	Steri-Strip INTACT	Assess
	1930	Midline incision to abd	Open to air /Steristrips/CDI	Assessed

SECTION IV - NOTES

70CT03 1740 Pt admitted from ICU2, Stable Condition. NKDA. [redacted] RN/BSN/MS

70CT03 1930: Pt awake & alert x 2, c/o pain. Lung sounds clear bilat, diminished to bases. non-productive cough, particularly in AM [redacted] RN/BSN

tx. Chest pt done

b(6) - 2 AIT

(b)(2)-2

ICU2 Pt [redacted] (b)(6)-4 8.0 ETT 26 @ lip

[redacted]

VENTILATOR FLOW SHEET

Alb Q4 + Atro Q8

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
3 Oct	0800	SIMV	16	800	40	5	26	16	91	97	83/49							
	1000	SIMV	24	800	94%	6	18	29	101	100	84/64							RHR
	1200			EXT														RRA TX

MEDCOM - 19605

b(6)-2

ICU2

Pt [redacted] b(6)-4

8 ⌀ ETT 26@ lip

[redacted]

VENTILATOR FLOW SHEET

Alb Q4 + Atro Q8

b(6)-2

ATT

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
30 Sep	0610	Simv	16	800	45	10	37	16	110	98	106/64							[redacted]
	0800	Simv	16	800	45	10	36	16	109	98	109/64							
	1000	Simv	16	800	45	10	38	24	114	99	111/61							
	1200	Simv	16	800	45	10	46	21	112	93	124/66							
	1400	Simv	16	800	45	10	40	17	106	97	125/67							
	1535	Simv	16	800	45	5	32	19	107	96	110/57							
	1729	Simv	16	800	45	5	34	16	104	97	101/50							BBS coarse
	1945	Simv	16	800	45	5	34	25	118	97	148/83							Atr + Sx OH
	2135	Simv	16	800	45	5	32	20	103	99	127/72							
1 Oct	0050	Simv	16	800	45	5	39	30	116	95	130/75							+ Sx Ad
	0405	Simv	16	800	45	5	30	16	101	98	125/68							Pt awake + moving above
	0510	Simv	16	800	40	5	31	18	104	100	114/63							Alb+Atro + Sx VF 4
	0800	Simv	16	800	40	5	31	16	100	96	108/64							Alb + Sx @ 1030
	1000	Simv	16	800	40	5	32	16	100	96	103/63							
	1100	CT				5	34											
	1400	Simv	16	800	40	5	34	16	99	99	89/58							
	1531	Simv	16	800	40	5	33	19	108	98	84/54							
	1739	Simv	16	800	40	5	33	19	92	98	110/59							BS coarse
	1927	Simv	16	800	40	5	33	16	101	98	122/66							Atro Sx
	2124	Simv	16	800	40	5	38	28	124	96	140/72							Sx Sc
	2305	Simv	16	800	40	5	33	18	112	95	126/63							
2 Oct	0150	Simv	16	800	40	5	33	19	116	95	128/68							
	0450	Simv	16	800	40	5	32	29	118	98	134/72							Alb+Atro + Sx
	0800	Simv	16	800	40	5	29	16	102	97	110/58							Alb + Sx
	1030	Simv	16	800	40	5	28	16	114	97	128/79							CTA
	1200	Simv	16	800	40	5	30	16	104	100	85/42							Sx Tx
	1438	Simv	16	800	40	5	37	19	106	98	95/48							
	1538	Simv	16	800	40	5	34	30	112	94	100/51							Tx
	1802	Simv	16	800	40	5	33	22	105	96	100/52							Sx by nurse
	1944	Simv	16	800	40	5	29	16	98	97	97/51							Atro
	2128	Sim	16	800	40	5	29	17	104	97	94/54							
	2336	Simv	16	800	40	5	28	15	99	98	98/53							Tx Sx OAH
	0120	Simv	16	800	40	5	33	23	103	98	90/56							⊕ wheezing
	0330	Simv	16	800	40	5	28	20	101	97	93/56							but ETT BS shed Alb + Atro + Sx coarse
	0535	Simv	16	800	40	5	36	16	99	96	96/56							Alb + Sx

PT'S NAME # [redacted] b(6)-4

DATE: 04OCT03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	0
BP INV	137/69	144/68	144/75	122/[illegible]				130/60	125/65	114/68	126/62	123/58	145/71	113/55	131/68	130/68	120/63	95/56	114/62	122/61	111/59	106/53	112/55	
BP NIBP	122/69	120/70	116/75		139/71	125/64	128/[illegible]	111/67	126/64	125/65	119/56													
TEMP	99.2	98.3	99.2	99.1		99.1	98.7	98.9		99.1		99.7		99.4		100		100		99		99		
PULSE	110	101	104	103	101	96	111	100	99	109	101	108	104	110	102	104	107	102	101	103	103	96	92	
RESP	30	24	26	26	36	37	24	41	49	36	39	40	50	38	34	36	40	40	38	42	38	36	24	
SP02	95	96	95	94	93	96	92	94	93	90	90	90	94	94	92	94	94	100	100	99	99	100	99	
FIO2	3L	[illegible]	[illegible]	3L	3L	6L	6L	6L	6L	6L	6L	15L	15L	15L	15L	15L	15L	15L	15L	15L				
Source	NC	[illegible]	NC	NC	NC	NC	NC	NC	NC	[illegible]	FM	NR	NR	NR	NR	NR	NR	Venti →						
Chest PT q2°											[illegible]		WDL	WDL	RT	WDL	RSO		WDL		WDL		WDL	
NT Suction q2°											[illegible]		WDL		RT				RT					
INPUT																								
IV D5½NS	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	12[illegible]	2
c 20mEq KCL																								
NPB				200												100						100		
Heparin	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	2[illegible]
PO		200																						
NGT																								
O.R. IN																								
SUB TOTAL			145		145	145	145	145	145	145	145	145	145	145	145	245	145	145	145	145	145	245	145	14[illegible]
TOTAL	145	590	735	1080	1225	1370	1515	1660	1805	1950	2095	2230	2375	2510	2655	2900	3045	3290	3435	3580	3725	3970	4115	42[illegible]
OUTPUT																								
URINE	200	160	140	160		400		180	200	200	140	180	225	200	175	250	150	175	150	225	150	125	125	
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL	200	360	500	660		1060		1240	1440	1640	1780	1960	2185	2285	2460	2710	2860	3035	3185	3410	3560	3685	3810	
BALANCE																								

MEDCOM - 19607

PT'S NAME: [redacted] b(6)-4

DATE: 06 OCT 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05
BP INV	144/78		123/69	132/71	1?/76	120/63	118/61	120/61			115/65	108/54	112/56	118/62	121/63	119/63	123/80	120/66	122/59	111/58	112/54	119/60	115/61
BP NIBP																							
TEMP	98³	98⁴	98⁷	986	98⁴	98⁶	98⁴	98⁴	986	98⁴	98⁴	992	988	99⁰	985	985	989	982	986	984		988	
PULSE	107	90	94	89	101	97	94	92	94	95	95	93	91	92	89	92	107	103	95	96	98	94	95
RESP	12	14	28	30	36	27	28	23	23	27	30	23	26	23	27	18	33	33	24	26	25	26	27
SP02	93	96	96	98	94	97	97	99				97	96	98	97	98	95	95	96	99	96	95	96
FIO2																							
O2 rate	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	1L	1L	1L	1L	1L	1L	4L	0.5L	.5L	.5L	.5L	.5L	.5L
Source	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC (up in Chair)	NC	NC	NC	NC	NC	NC
INPUT																							
IV																							
D5½NS+20K	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	12
Heparin	20	20	20	20	20	20	20	20															
IVPB				100																		100	
PO	240		240															240					
NGT																							
O.R. IN																							
SUB TOTAL		145	385	345	145	145	145	145	125	125	125	125	125	125	125	125	125	375	125	125	125	125	125
TOTAL	385	530	915	1260	1405	1550	1695	1845	1970	2095	2220	2345	2470	2595	2720	2845	2970	3345	3470	3595	3720	3845	3970
OUTPUT																							
URINE	200	200	400	200	220	160	170	200			130	130	660	200	200	150	275	200	200	225	250	300	200
NGT																							
STOOL																							
O.R. OUT																							
SUBTOTAL																							
TOTAL											130	130	660	200	200	150	275	200	200	225	250	300	200
BALANCE	200	400	600	460	1105	1220	1410	1630			1760	1880	2540	2740	2940	3090	3365	3565	3765	3940	4340	4540	4740

MEDCOM - 19608

PT'S NAME: # [redacted] J-1-13-A

DATE: 05 Oct 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV	128/58	117/63	129/69	114/61	114/61	114/63	120/63	114/67	121/67	126/72	118/64	136/68	149/78	107/56	114/55	144/75	151/78	127/70	129/67	127/63	121/65	117/64	117/64	123/
BP NIBP	110/66	107/50																						
TEMP	98°	98°	98°	98.6	98.7	98.4	98.4	98.0	98.1	98.6	98.1	98.6	99.1					98.6			99.1			99.
PULSE	92	84	91	94	101	96	101	98	96	89	100	89	92	92	93	96	116	97	106	93	94	91	93	97
RESP	30	28	29	24	31	26	34	27	29	31	36	33	39	29	18	15	27	32	29	21	26	28	30	16
SP02	96%	98%	98%	98	97	96	98	92%	100	97	91	96	100	96	100	94	98	95	97	97	98	95	95	96
FIO2	40	40	40																					
O2 Rate	6L	6L	4L	4L	4L	4L	4L	6L	4L	4L	4L	4L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	4L
Route	Ventil	Ventil	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
INPUT																								
IV D5 1/2 NS 20K	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
H-Lyte	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
D/C'D				200													100					100		
PO		360				400					240													
NGT																								
O.R. IN																								
SUB TOTAL													145	145	145	145	245	145	145	145	145	245	145	14
TOTAL	145	680	795	1135	1380	2935	3075	3315	3440	3585	3985	3885	4425	4170	4315	4460		4850		5040		5470		56
OUTPUT																								
URINE	200	200	200	160	150	100	100	100	140	100	100	100	301	120	260	190	-	-	370		850		340	12
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL													300	120	260	190	-	-	370		850		340	12
TOTAL	200	400	600	760	940	1040	1140	1240	1380	1480	1580	1680	1980	2600	2860	3050			3420		3770		4110	42
BALANCE																								

MEDCOM - 19609

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR 19 | DAY 14 Oct 03 | 15 Oct | 16 Oct | 17 Oct 03 | 18/18
HOUR 0700 | 0700

PULSE (O) | TEMP. F (°)

105° 180 104° 170 103° 160 102° 150 101° 140 100° 130 99° 98.6° 120 98° 110 97° 100 96° 90 95° 80 70 60 50 40

TEMP. C: 40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

[redacted]

b(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR OCT 2003 | DAY | HOUR

PULSE (O) | TEMP. F (°)

105° | 104° | 103° | 102° | 101° | 100° | 99° | 98.6° | 98° | 97° | 96° | 95°

180 | 170 | 160 | 150 | 140 | 130 | 120 | 110 | 100 | 90 | 80 | 70 | 60 | 50 | 40

TEMP. C

40.6° | 40.0° | 39.4° | 38.9° | 38.3° | 37.8° | 37.2° | 37.0° | 36.7° | 36.1° | 35.6° | 35.0°

(Centigrade Equivalents, for Reference only)

8 OCT 03 | 9 OCT 03 | 10 OCT 03 | 11 OCT 0200 1900 | 12 OCT 0200 | 13 OCT 08 1820

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT → 95#

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

EPW [redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 19611

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 18OCT03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1900	H2O	200	
1900	juice	240	440cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
?	1000	D5NS c 20KCl	950cc	0200	950cc

IRRIGATIONS ~~(IV/G, Bladder, etc.)~~ (FOLEY)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0100	amber urine	700	700cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

[redacted]

b(6)-4

Ward/Section: 1CM2	REQ [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted]		DATE 07Oct	TIME 0330
SSN/PEEUDO SSN:			

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10	Color	b(6)-4	N/A	RPR		Negative
RBC		4.7-6.1 x10	App		N/A	Mono		Negative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu		Negative	Microbiology		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative	Gram Stain		
Plt		130-500 x10³ verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono		Prot		Negative	Malaria	
Bands		Eos		Urob		0.2-1.0	O & P	
Lymph		Baso		Nit		Negative	Other	
Atyp		Imm		Leuk		Negative	Macroscopic Urinalysis	
RBC Morph				HCG		Negative		
Spun Hematocrit		42-52%(M) 37-47%(F)	CSF			Blood Bank		
Set Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 SESS			
D dimer		<20 ug/ml			
FDP		< 10 ug /ml			

REMARKS: CBC, PT PTT, Chem 8

REPORTED BY: DATE: LAB ID NO.:

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section: ICU #1

REQUESTING PHYSICAN: [redacted] b(6)-2

DATE: 15 OCT

TIME: 1110

LAST, FIRST,MI. b(6)-4 EPW [redacted]

SSN/REFUDO SSN: [redacted] EPW b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dl
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (a 41-51 mmHg (v
PO2		80-105 mmHg (N/A (ven)
TCO2		23-27 mmol/L (24-29 mmol/L (
HCO3		22-26 mmol/L (23-28 mmol/L (
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANG
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF.

======= PICCOLO =======

15/10/03 11:25

REFERENCE RANGE: MALE

PATIENT #: [redacted] b(6)-4

GENERAL CHEMISTRY 12

DISC LOT #: 3204AA1

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	2.9*	3.3-5.5	G/DL
ALP	101*	26-84	U/L
ALT	15	10-47	U/L
AMY	103*	14-97	U/L
AST	21	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
BUN	9	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CHOL	127	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	104	73-118	MG/DL
TP	7.9	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 1+, LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======

15/10/03 11:24

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: b(6)-2 3152AA1

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	102	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	53	39-380	U/L
~~NA+~~	~~128~~	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	96*	98-108	MMOL
tCO2	20	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

NA

133

REMARKS: CBC + Chemistry

REPORTED BY: | DATE: | LAB ID NO.:

b(6)-2

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

I/Section: ICW#1	REQUESTING PHYSICIAN: [redacted]	DATE: 15 Oct	TIME:
T, FIRST, MI: [redacted] EPW#1 b(6)-4			SSN/PEERID SSN: [redacted] EPW b(6)-4

(Hematology) CBC

ST	RESULT	REF. RANGE
BC		4.8-10.8 x10
BC		4.7-6.1 x10
gb		14-18 g/dl(M) 12-16 g/dl(F)
ct		42-52%(M) 37-47%(F)
ICV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52%(M) 37-47%(F)
Set Rate		
Other		

Urinalysis Foley

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.020	N/A
Bld	mod	Negative
pH	6.0	N/A
Prot	Trace	Negative
Urob	2+	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Macroscopic Urinalysis

SSA - Trace TRACE-BACT
3-5 RBC
~~Protein~~ - EPIRELLS-10

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2

DATE: 15 Oct 05

LAB ID NO.:

MEDCOM - 19615

b(6)-2

Ward/Section: EMT

REQUESTING PHYSICIAN: [redacted]

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, M: EPW [redacted] b(6)-4

DATE: 19/09/03

TIME: 0125

SSN/PSEUDO SSN: [redacted] b(6)-4

(ESTA) Piccolo Chemistry 12

TEST	RESULT	REF. RA
Na		138-146 mm
K		3.5-4.9 mm
Cl		98-109 mm
pH		7.31-7.45
PCO2		35-45 mm 41-51 mmH
PO2		80-105 mm N/A (ven)
TCO2		23-27 mmo 24-29 mm
HCO3		22-26 mm 23-28 mm
sO2		95-98%
BEecf		(-2) – (+ mmol/L
AnGap		10-20 m
Ca		1.12-1.3
BUN		8-26 m
GLU		70-105
Creat		0.7-1.5
Hct		38-51
Hgb		12-17

Misc. Chemistry

TEST	RESULT	REF
Troponin-I		
Drug of Abuse		

REM: [redacted] b(6)-2

REPORTED BY:

DATE:

LAB ID NO

======= PICCOLO =======
19/09/03 01:46
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

ALB	2.9*	3.3-5.5	G/DL
ALP	39	26-84	U/L
ALT	18	10-47	U/L
AMY	56	14-97	U/L
AST	33	11-38	U/L
TBIL	0.3	0.2-1.6	MG/DL
BUN	6*	7-22	MG/DL
CA++	7.6*	8.0-10.3	MG/DL
CHOL	110	100-200	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
GLU	135*	73-118	MG/DL
TP	5.9*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0, ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

======= PICCOLO =======
19/09/03 01:45
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	127*	73-118	MG/DL
BUN	8	7-22	MG/DL
CA++	7.6*	8.0-10.3	MG/DL
CRE	1.6*	0.6-1.2	MG/DL
NA+	136	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0, LIP 0, ICT 0

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: EPW [redacted] b(6)-4	DATE	TIME	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram Stain	
Occ Bld	Negative
H. pylori	Negative
Micro Parasites	
Malaria	
O & P	
Other	

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh: AB pos

REMARKS:

REPORTED BY: | **DATE:** | **LAB ID NO.:**

MEDCOM - 19617

Ward/Section:	REQUESTING PHYSICAN: b(6)-4	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	DATE	TIME	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF.

======= PICCOLO =======
09/26/03 03:54 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-2
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA1
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-4 [redacted]

ALB	2.3*	3.3-5.5	G/DL
ALP	70	26-84	U/L
ALT	59*	10-47	U/L
AMY	53	14-97	U/L
AST	42*	11-38	U/L
TBIL	2.1*	0.2-1.6	MG/DL
BUN	10	7-22	MG/DL
CA++	8.5	8.0-10.3	MG/DL
CHOL	93*	100-200	MG/DL
CRE	1.1	0.6-1.2	MG/DL
GLU	119*	73-118	MG/DL
TP	6.7	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		

======= PICCOLO =======
09/26/03 04:21 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-2
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-4 [redacted]

GLU	118	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	331	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	94*	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

Na-139 mmol/L

tCO2 16-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 26 Sep 03	LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. EPW # [redacted] b(6)-4	DATE 28/9	TIME 1700	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fl(M) 81-99 fl(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52%(M) 37-47%(F)	
Set Rate			
Other			

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

REMARKS: CBC / coags / RBG T: 101.1 FiO2 50%.

REPORTED BY: DATE: LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICAN: [redacted] b(6)-2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: b(6)-4 BPW [redacted]	DATE: 28/9	TIME: 1700	SSN/PEEUDO SSN:	

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
AL		
AM		
AS		
TB		
BU		
CA		
CH		
CR		
GL		
TP		
TE		
GLU		
BUN		
CRE		
CK		
NA+		
K+		
CL-		
tCO2		

PICCOLO
09/28/03 04:41 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA1
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: b(6)-2 [redacted]

GLU	128*	73-118	MG/DL
BUN	***	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	973*	39-380	U/L
NA+	***	128-145	MMOM
K+	4.2	3.3-4.7	MMOM
CL-	95*	98-108	MMOM
tCO2	25	18-33	MMOM

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 2+

Bun 9
Na 129

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/dl
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ST		
		3.3-5.5 g/dl
		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

T	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

REMARKS: met 8

REPORTED BY: DATE: 28Sep03 [redacted] LAB ID NO.:

Ward/Section: CM2	REQUESTING PHYSICAN: Dr. [redacted] b(4)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. b(4)-4 #[redacted]	DATE 04OCT03	TIME 0500	SSN/PEEUDO SSN: #[redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52%(M) 37-47%(F)	
Set Rate			
Other			

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: 1CU2	REQUESTING PHYSICAN: Dr. [redacted] b(6)-2			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. b(6)-2 # [redacted]		DATE 04OCT03	TIME 0500	SSN/PEEUDO SSN: # [redacted]	

(i-STAT)

TEST	RESULT	REF. RANGE
Na	128	138-146 mmol/dL
K	3.6	3.5-4.9 mmol/L
CI	99	98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	25	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	9	8-26 mg/dl
GLU	124	70-105 mg/dl
Creat	0.8	0.7-1.5 mg/dl
Hct	30	38-51% PCV
Hgb	10	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/dl
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AST		14-97 u/l
AMY		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b(6)-2 | DATE: | LAB ID NO.:

Ward/Section: ICU #2 | REQUESTING PHYSICIAN: [redacted] | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. b(6)-4 [redacted] | DATE 20SEP08 | TIME 0910 | SSN/[redacted] SSN: [redacted] b(6)-4

i-STAT

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (vca)
PO2		80-105 mmHg (art) N/A (vca)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (vca)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (vca)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
20/09/03 05:02
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] b(6)-2

GLU	114	73-118	MG/DL
BUN	15	7-22	MG/DL
CA++	7.6*	8.0-10.3	MG/DL
CRE	1.2	0.6-1.2	MG/DL
NA+	127*	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 ; LIP 0 , ICT 0

REMARKS: ABC

REPORTED BY: [redacted] DATE: 20SEP08 LAB ID NO.:

b(4)-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: Dr [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. #1 b(4)-4 [redacted]	DATE 19Sep05 TIME 0415	SSN/PSEUDO SSN: # [redacted] b(4)-3

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		
ALP		
ALT		
AMY		
AST		
TBIL		
BUN		
CA^{++}		
CHOL		
CRE		
GLU		
TP		

TEST	RESULT	REF. RANGE
GLU		
BUN		
CRE		
CK		
NA^{+}		
K^{+}		
CL^{-}		
tCO2		

PICCOLO
19/09/03 04:49
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(4)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(4)-2 [redacted]

GLU	149*	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	1536*	39-380	U/L
NA+	135	128-145	MMOL
K+	4.7	3.3-4.7	MMOL
CL-	111*	98-108	MMOL
tCO2	19	18-33	MMOL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/dl
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

(Piccolo) Liver Panel Plus

RESULT	REF. RANGE
	3.3-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/dl
	5-65 u/l
	6.4-8.1 g/dl

(Piccolo) Electrolyte

RESULT	REF. RANGE
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

tCO2

REMARKS: urine tox screen POS- BZO + OPI

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: ICU #2	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, [redacted] b(6)-4	DATE 19SEP	TIME 2020
		SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======
19/09/03 20:23
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] b(6)-2

GLU	122*	73-118	MG/DL
BUN	16	7-22	MG/DL
CA++	7.4*	8.0-10.3	MG/DL
CRE	1.2	0.6-1.2	MG/DL
NA+	132	128-145	MMOL/L
K+	4.9*	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0 , ICT 0

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU #2	REQUESTING PHYSICAN: [redacted] b(6)-2			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] b(6)-4		DATE 21 SEP 03	TIME 1121	SSN/PSEUDO SSN: [redacted] b(6)-4	

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.46	7.31-7.45
PCO2	36.1	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	71	80-105 mmHg (art) N/A (ven)
TCO2	27	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	26	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	95	95-98%
BEecf	2	(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/dl
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AST		14-97 u/l
AMY		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: 7CW2	REQUESTING PHYSICAN: Dr [redacted] b(6)-4	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST,M [redacted] b(6)-2		DATE 26Sep	TIME 0345

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF	TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL	ALB					
K		3.5-4.9 mmol/L	ALP					
Cl		98-109 mmol/L	ALT					
pH		7.31-7.45	AMY					
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST					
PO2		80-105 mmHg (art) N/A (ven)	TBIL					
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN					
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)	CA^{++}					
SO2		95-98%	CHOL		1			
BEecf		(-2) - (+3) mmol/L	CRE		0			
AnGap		10-20 mmol/L	GLU		7			
Ca		1.12-1.32 mmol/L	TP		6			
BUN		8-26 mg/dl	(Piccolo) Metlyte					
GLU		70-105 mg/dl	TEST	RESULT				
Creat		0.7-1.5 mg/dl	GLU		73			
Hct		38-51% PCV	BUN		7-2			
Hgb		12-17 g/dl	CRE		0.6-			
Misc. Chemistry			CK		39-3 30-1			
TEST	RESULT	REF. RANGE	NA^+		128-			
Tropoin-I			K^+		3.3-4			
Drug of Abuse			CL^-		98-1(			
			tCO2		18-33			
						CL		98-108 mmol/l
						tCO2		18-33 mmol/l

======= PICCOLO =======
09/26/03 03:51 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AAM
OPER #: [redacted] b(6)-2 DR #: 000
SERIAL #: b(6)- [redacted]

GLU	110	73-118	MG/DL
BUN	11	7-22	MG/DL
CA++	8.2	8.0-10.3	MG/DL
CRE	0.8	0.6-1.2	MG/DL
NA+	~~112*~~ 130	28-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

REMARKS:		
REPORTED BY:	DATE.	LAB ID NO.:

Ward/Section: TCCU	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 2350703	TIME: 1200
		SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fl(M) 81-99 fl(F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52%(M) 37-47%(F)
Set Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram Stain	
Occ Bld	Negative
H. pylori	Negative
Micro Parasites	
Malaria	
O & P	
Other	

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: CBC diff. Lab and SIR from fusion 2 Units RBCs

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 19628

Ward/Section: ICU2

REQUESTING PHYSICAN:

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST [redacted] DATE 22SEP03 TIME 2200 SSN/PEEUDO SSN: [redacted]

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======
22/09/03 22:18
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....blood.....

GLU	100	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	0.5*	0.6-1.2	MG/DL
CK	1342*	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

I-Stat
NA - 135
Bun - 8

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/dl
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AST		14-97 u/l
AMY		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS: Chem 8

REPORTED BY: DATE: LAB ID NO.:

Ward/Section: ICU 2	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST MI: [redacted] b(6)-4	DATE: 9/23/07 TIME: 1010	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/dl
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AST		14-97 u/l
AMY		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

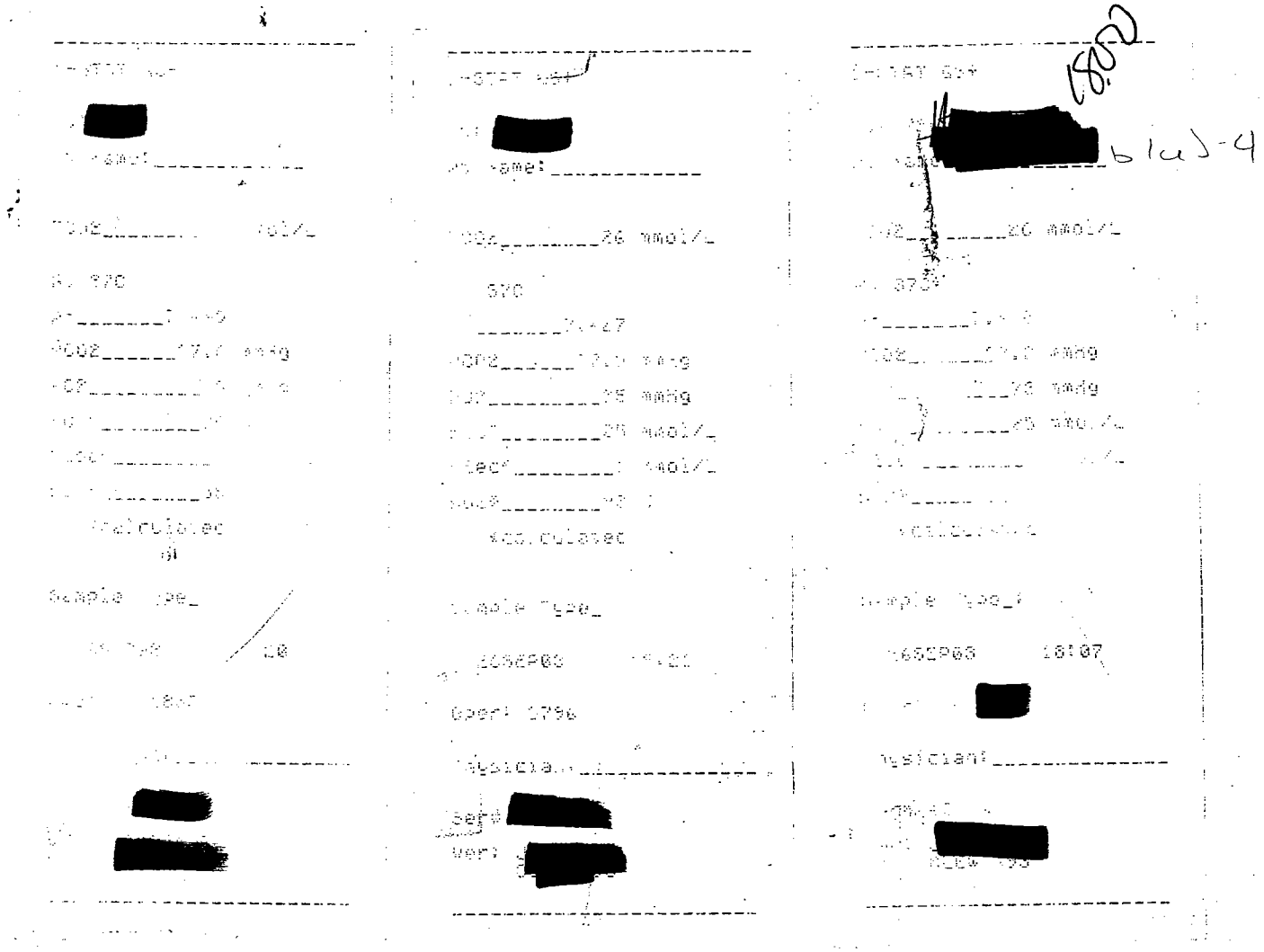
(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

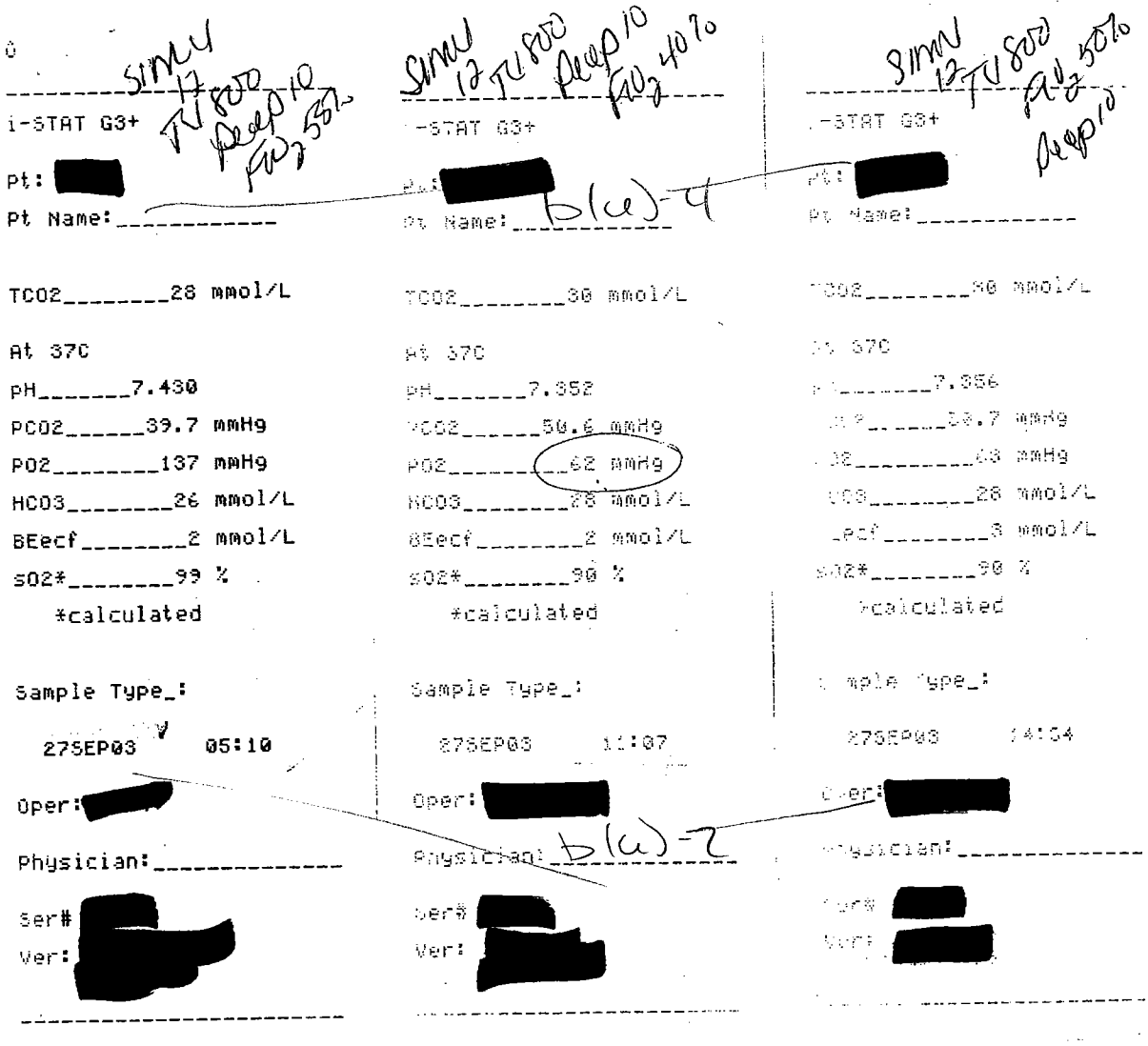
REMARKS:

REPORTED BY: b(6)-2 [redacted] DATE: 2355 LAB ID NO.:

Temp 98.4
FIO2 45%



MEDCOM - 19631



SIMV 12 TV 800 PEEP 10 FiO2 35%

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____28 mmol/L

At 37C

pH_____7.430

PCO2_____39.7 mmHg

PO2_____137 mmHg

HCO3_____26 mmol/L

BEecf_____2 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

27SEP03 05:10

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

SIMV 12 TV 800 PEEP 10 FiO2 40%

i-STAT G3+

Pt: [redacted]

Pt Name:_____ b(6)-4

TCO2_____30 mmol/L

At 37C

pH_____7.352

PCO2_____50.6 mmHg

PO2_____62 mmHg

HCO3_____28 mmol/L

BEecf_____2 mmol/L

sO2*_____90 %

*calculated

Sample Type_:

27SEP03 11:07

Oper: [redacted]

Physician:_____ b(6)-2

Ser# [redacted]

Ver: [redacted]

SIMV 12 TV 800 FiO2 50% PEEP 10

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____30 mmol/L

At 37C

pH_____7.356

PCO2_____50.7 mmHg

PO2_____63 mmHg

HCO3_____28 mmol/L

BEecf_____3 mmol/L

sO2*_____90 %

*calculated

Sample Type_:

27SEP03 14:34

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

b(a)-4

ID: [redacted] 26-09-03
WB 15:51

				Patient Limits	
WBC	2.8	L	x10^3/uL	4.5	10.5
RBC	3.51	L	x10^6/uL	4.00	6.00
Hgb	9.6	L	g/dL	11.0	18.0
Hct	30.8	L	%	35.0	60.0
MCV	87.6		fL	80.0	99.9
MCH	27.4		pg	27.0	31.0
MCHC	31.3	L	g/dL	33.0	37.0
Plt	209.	*	x10^3/uL	150.	450.
LY%	31.5	*	%	20.5	51.1
LY#	0.9	*L	x10^3/uL	1.2	3.4

ID: [redacted] 26-09-03
WB 23:05

				Patient Limits	
WBC	20.8	H	x10^3/uL	4.5	10.5
RBC	3.81	L	x10^6/uL	4.00	6.00
Hgb	10.4	L	g/dL	11.0	18.0
Hct	33.4	L	%	35.0	60.0
MCV	87.5		fL	80.0	99.9
MCH	27.4		pg	27.0	31.0
MCHC	31.3	L	g/dL	33.0	37.0
Plt	381.		x10^3/uL	150.	450.
LY%	4.6	*L	%	20.5	51.1
LY#	1.0	*L	x10^3/uL	1.2	3.4

ID: [redacted] 26-09-03
WB 03:56

				Patient Limits	
WBC	11.2	*H	x10^3/uL	4.5	10.5
RBC	3.61	L	x10^6/uL	4.00	6.00
Hgb	9.8	L	g/dL	11.0	18.0
Hct	31.6	L	%	35.0	60.0
MCV	87.5		fL	80.0	99.9
MCH	27.3		pg	27.0	31.0
MCHC	31.2	L	g/dL	33.0	37.0
Plt	357.		x10^3/uL	150.	450.
LY%	18.4	*L	%	20.5	51.1
LY#	2.1	*	x10^3/uL	1.2	3.4

ID: [redacted] 26-09-03
WB 18:33

				Patient Limits	
WBC	9.8		x10^3/uL	4.5	10.5
RBC	2.78	L	x10^6/uL	4.00	6.00
Hgb	7.6	L	g/dL	11.0	18.0
Hct	24.9	L	%	35.0	60.0
MCV	89.4		fL	80.0	99.9
MCH	27.4		pg	27.0	31.0
MCHC	30.6	L	g/dL	33.0	37.0
Plt	160.	*	x10^3/uL	150.	450.
LY%	4.7	*L	%	20.5	51.1
LY#	0.5	*L	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL # [redacted] 09/26/03 11:07 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.8 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.22
Sample Type:citrated wh. blood
Test Date :09/26/03
Test Time :11:06 PM
Card Lot :040302
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/26/03 03:53 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.5 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.3
[redacted]
Sample Type:citrated wh. blood
Test Date :09/26/03
Test Time :03:51 PM
Card Lot :040302
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/26/03 11:10 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 30.0 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/26/03
Test Time :11:07 PM
Card Lot :100208
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/26/03 03:56 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 27.4 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/26/03
Test Time :03:54 PM
Card Lot :100208
Operator [redacted]

b(6)-4

ID: [redacted] 25-09-03
WB 15:27

				Patient Limits	
WBC	9.3		x10^3/uL	4.5	10.5
RBC	3.27	L	x10^6/uL	4.00	6.00
Hgb	8.9	L	g/dL	11.0	18.0
Hct	28.9	L	%	35.0	60.0
MCV	88.4		fL	80.0	99.9
MCH	27.3		pg	27.0	31.0
MCHC	30.9	L	g/dL	33.0	37.0
Plt	339.		x10^3/uL	150.	450.
LY%	18.4	*L	%	20.5	51.1
LY#	1.7	*	x10^3/uL	1.2	3.4

ID: [redacted] 24-09-03
WB 15:48

				Patient Limits	
WBC	11.0	*H	x10^3/uL	4.5	10.5
RBC	3.56	L	x10^6/uL	4.00	6.00
Hgb	10.1	L	g/dL	11.0	18.0
Hct	31.2	L	%	35.0	60.0
MCV	87.6		fL	80.0	99.9
MCH	28.2		pg	27.0	31.0
MCHC	32.2	L	g/dL	33.0	37.0
Plt	294.		x10^3/uL	150.	450.
LY%	14.2	*L	%	20.5	51.1
LY#	1.6	*	x10^3/uL	1.2	3.4

ID: [redacted] 23-09-03
WB 08:29

				Patient Limits	
WBC	9.5		x10^3/uL	4.5	10.5
RBC	3.25	L	x10^6/uL	4.00	6.00
Hgb	9.2	L	g/dL	11.0	18.0
Hct	28.9	L	%	35.0	60.0
MCV	88.8		fL	80.0	99.9
MCH	28.3		pg	27.0	31.0
MCHC	31.8	L	g/dL	33.0	37.0
Plt	215.		x10^3/uL	150.	450.
LY%	18.4	*L	%	20.5	51.1
LY#	1.8	*	x10^3/uL	1.2	3.4

ID: [redacted] 24-09-03
WB 04:19

				Patient Limits	
WBC	8.9		x10^3/uL	4.5	10.5
RBC	3.39	L	x10^6/uL	4.00	6.00
Hgb	9.6	L	g/dL	11.0	18.0
Hct	29.7	L	%	35.0	60.0
MCV	87.6		fL	80.0	99.9
MCH	28.4		pg	27.0	31.0
MCHC	32.4	L	g/dL	33.0	37.0
Plt	255.		x10^3/uL	150.	450.
LY%	19.7	*L	%	20.5	51.1
LY#	1.8	*	x10^3/uL	1.2	3.4

ID: [redacted] 23-09-03
WB 15:08

				Patient Limits	
WBC	8.9		x10^3/uL	4.5	10.5
RBC	3.30	L	x10^6/uL	4.00	6.00
Hgb	9.2	L	g/dL	11.0	18.0
Hct	28.9	L	%	35.0	60.0
MCV	87.6		fL	80.0	99.9
MCH	27.9		pg	27.0	31.0
MCHC	31.8	L	g/dL	33.0	37.0
Plt	234.		x10^3/uL	150.	450.
LY%	19.3	*L	%	20.5	51.1
LY#	1.7	*	x10^3/uL	1.2	3.4

b(6)-4

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____26 mmol/L

At 37C

PH_____7.450

PCO2_____36.3 mmHg

PO2_____50 mmHg

HCO3_____25 mmol/L

BEecf_____1 mmol/L

sO2*_____87 %

*calculated

At Patient Temp

PH_____7.448

PCO2_____36.6 mmHg

PO2_____50 mmHg

Patient Temp: 98.9F

FIO2_____: 95

Sample Type_: ART

[redacted] 10:18

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

======= PICCOLO =======
25/09/03 03:56
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	105	73-118	MG/DL
BUN	12	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	[redacted] 13(	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

b(6)-2

ID: [redacted]
WB

20-09-03
00:21

			Patient Limits	
WBC	7.7	x10^3/uL	4.5	10.5
RBC	2.91 L	x10^6/uL	4.00	6.00
Hgb	8.3 L	g/dL	11.0	18.0
Hct	25.5 L	%	35.0	60.0
MCV	87.6	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	32.5 L	g/dL	33.0	37.0
Plt	148. L	x10^3/uL	150.	450.
LY%	19.9 L	%	20.5	51.1
LY#	1.5	x10^3/uL	1.2	3.4

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____29 mmol/L

At 37C

PH_____7.487

PCO2_____36.5 mmHg

PO2_____110 mmHg

HCO3_____28 mmol/L

BEecf_____4 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

20SEP03 04:39

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

ID: [redacted]
WB

20-09-03
04:58

			Patient Limits	
WBC	8.5	x10^3/uL	4.5	10.5
RBC	2.99 L	x10^6/uL	4.00	6.00
Hgb	8.6 L	g/dL	11.0	18.0
Hct	26.7 L	%	35.0	60.0
MCV	89.3	fL	80.0	99.9
MCH	28.9	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	149. L	x10^3/uL	150.	450.
LY%	17.5 *L	%	20.5	51.1
LY#	1.5 *	x10^3/uL	1.2	3.4

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____27 mmol/L

At 37C

PH_____7.557

PCO2_____29.3 mmHg

PO2_____62 mmHg

HCO3_____26 mmol/L

BEecf_____4 mmol/L

sO2*_____94 %

*calculated

Sample Type_:

20SEP03 19:08

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

ID: [redacted]
WB

20-09-03
12:33

			Patient Limits	
WBC	9.1	x10^3/uL	4.5	10.5
RBC	3.33 L	x10^6/uL	4.00	6.00
Hgb	9.5 L	g/dL	11.0	18.0
Hct	29.8 L	%	35.0	60.0
MCV	89.3	fL	80.0	99.9
MCH	28.6	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	146. L	x10^3/uL	150.	450.
LY%	15.1 *L	%	20.5	51.1
LY#	1.4 *	x10^3/uL	1.2	3.4

i-STAT EG7+

Pt: [redacted]

Pt Name:_____

Na_____133 mmol/L

K_____3.7 mmol/L

TCO2_____25 mmol/L

iCa_____1.04 mmol/L

Hct_____27 %PCV

Hb*_____9 g/dL

*via Hct

At 37C

PH_____7.517

PCO2_____29.9 mmHg

PO2_____81 mmHg

HCO3_____24 mmol/L

BEecf_____1 mmol/L

sO2*_____97 %

*calculated

Sample Type_:

20SEP03 16:33

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

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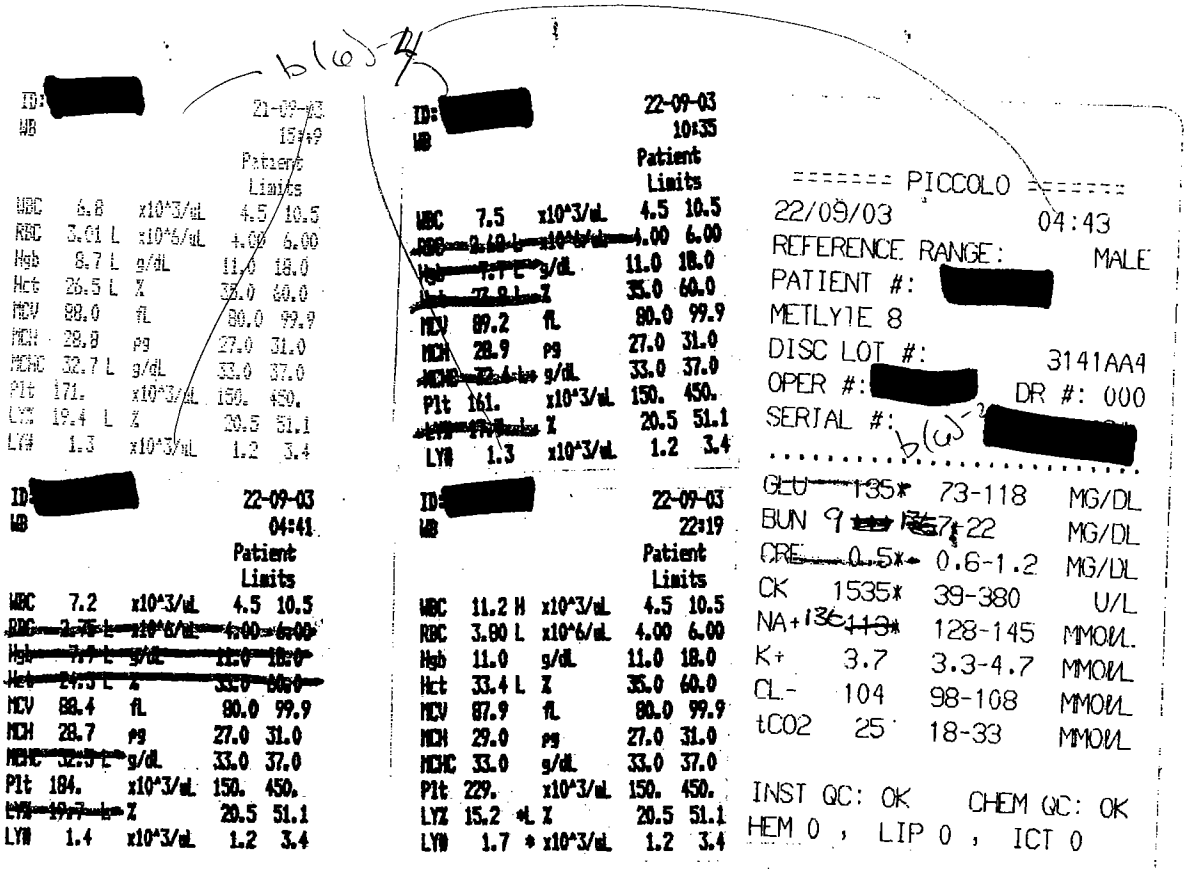
blw-4

blw-2



ID: [redacted]
WB 21-09-03 15:49

			Patient Limits	
WBC	6.8	x10^3/uL	4.5	10.5
RBC	3.01 L	x10^6/uL	4.00	6.00
Hgb	8.7 L	g/dL	11.0	18.0
Hct	26.5 L	%	35.0	60.0
MCV	88.0	fL	80.0	99.9
MCH	28.8	pg	27.0	31.0
MCHC	32.7 L	g/dL	33.0	37.0
Plt	171.	x10^3/uL	150.	450.
LY%	19.4 L	%	20.5	51.1
LY#	1.3	x10^3/uL	1.2	3.4

ID: [redacted]
WB 22-09-03 04:41

			Patient Limits	
WBC	7.2	x10^3/uL	4.5	10.5
RBC	[redacted]			
Hgb	[redacted]			
Hct	[redacted]			
MCV	88.4	fL	80.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	[redacted]			
Plt	184.	x10^3/uL	150.	450.
LY%	[redacted]			
LY#	1.4	x10^3/uL	1.2	3.4

ID: [redacted]
WB 22-09-03 10:35

			Patient Limits	
WBC	7.5	x10^3/uL	4.5	10.5
RBC	[redacted]			
Hgb	[redacted]			
Hct	[redacted]			
MCV	89.2	fL	80.0	99.9
MCH	28.9	pg	27.0	31.0
MCHC	[redacted]			
Plt	161.	x10^3/uL	150.	450.
LY%	[redacted]			
LY#	1.3	x10^3/uL	1.2	3.4

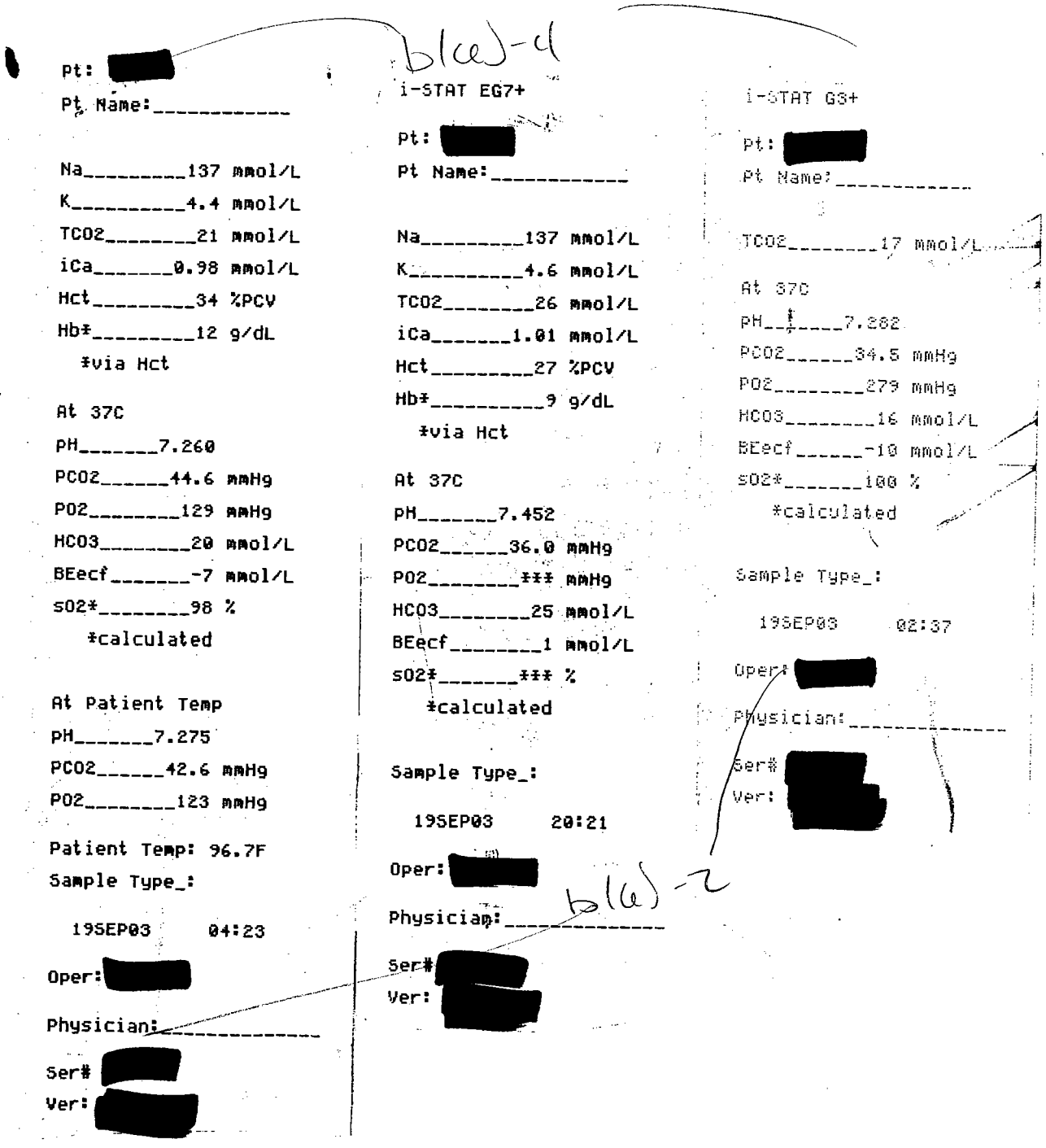
ID: [redacted]
WB 22-09-03 22:19

			Patient Limits	
WBC	11.2 H	x10^3/uL	4.5	10.5
RBC	3.80 L	x10^6/uL	4.00	6.00
Hgb	11.0	g/dL	11.0	18.0
Hct	33.4 L	%	35.0	60.0
MCV	87.9	fL	80.0	99.9
MCH	29.0	pg	27.0	31.0
MCHC	33.0	g/dL	33.0	37.0
Plt	229.	x10^3/uL	150.	450.
LY%	15.2 *L	%	20.5	51.1
LY#	1.7 *	x10^3/uL	1.2	3.4

======= PICCOLO =======
22/09/03 04:43
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	135*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	0.5*	0.6-1.2	MG/DL
CK	1535*	39-380	U/L
NA+	136	128-145	MMOL
K+	3.7	3.3-4.7	MMOL
CL-	104	98-108	MMOL
tCO2	25	18-33	MMOL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0



Pt: [redacted]
Pt Name:_____

Na_____137 mmol/L
K_____4.4 mmol/L
TCO2_____21 mmol/L
iCa_____0.98 mmol/L
Hct_____34 %PCV
Hb*_____12 g/dL
*via Hct

At 37C
PH_____7.260
PCO2_____44.6 mmHg
PO2_____129 mmHg
HCO3_____20 mmol/L
BEecf_____-7 mmol/L
sO2*_____98 %
*calculated

At Patient Temp
PH_____7.275
PCO2_____42.6 mmHg
PO2_____123 mmHg

Patient Temp: 96.7F
Sample Type_:

19SEP03 04:23

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver: [redacted]

b1(6)-4

i-STAT EG7+

Pt: [redacted]
Pt Name:_____

Na_____137 mmol/L
K_____4.6 mmol/L
TCO2_____26 mmol/L
iCa_____1.01 mmol/L
Hct_____27 %PCV
Hb*_____9 g/dL
*via Hct

At 37C
PH_____7.452
PCO2_____36.0 mmHg
PO2_____*** mmHg
HCO3_____25 mmol/L
BEecf_____1 mmol/L
sO2*_____*** %
*calculated

Sample Type_:

19SEP03 20:21

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver: [redacted]

b1(6)-2

i-STAT GS+

Pt: [redacted]
Pt Name:_____

TCO2_____17 mmol/L

At 37C
PH_____7.282
PCO2_____34.5 mmHg
PO2_____279 mmHg
HCO3_____16 mmol/L
BEecf_____-10 mmol/L
sO2*_____100 %
*calculated

Sample Type_:

19SEP03 02:37

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver: [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/19/03 01:50 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 21.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :01:47 AM
Card Lot :100208
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/19/03 01:52 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.6 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.19
Sample Type:citrated wh. blood
Test Date :09/19/03
Test Time :01:51 AM
Card Lot :010301
Operator : [redacted]

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____22 mmol/L

At 37C

pH_____7.391

PCO2_____34.6 mmHg

PO2_____92 mmHg

HCO3_____21 mmol/L

BEecf_____-4 mmol/L

sO2*_____97 %

*calculated

Sample Type_:

[redacted] 12:48

Oper: 0

Physician:_____

Ser# [redacted]

Ver: [redacted]

ID: [redacted] 19-09-03
WB 04:26

				Patient Limits
WBC	10.0	x10^3/uL		4.5 10.5
RBC	3.85	L x10^6/uL		4.00 6.00
Hgb	10.9	L g/dL		11.0 18.0
Hct	33.6	L %		35.0 60.0
MCV	87.3	fL		80.0 99.9
MCH	28.2	pg		27.0 31.0
MCHC	32.3	L g/dL		33.0 37.0
Plt	219.		x10^3/uL	150. 450.
LY%	17.7	*L %		20.5 51.1
LY#	1.8	* x10^3/uL		1.2 3.4

ID: [redacted] 19-09-03
WB 20:25

				Patient Limits
WBC	9.0	x10^3/uL		4.5 10.5
RBC	3.06	L x10^6/uL		4.00 6.00
Hgb	8.8	L g/dL		11.0 18.0
Hct	27.0	L %		35.0 60.0
MCV	88.4	fL		80.0 99.9
MCH	28.7	pg		27.0 31.0
MCHC	32.5	L g/dL		33.0 37.0
Plt	140.	L	x10^3/uL	150. 450.
LY%	21.4	* %		20.5 51.1
LY#	1.9	* x10^3/uL		1.2 3.4

ID: [redacted] 19-09-03
WB 07:44

				Patient Limits
WBC	14.1	H x10^3/uL		4.5 10.5
RBC	4.02	x10^6/uL		4.00 6.00
Hgb	11.4	g/dL		11.0 18.0
Hct	35.1	%		35.0 60.0
MCV	87.3	fL		80.0 99.9
MCH	28.3	pg		27.0 31.0
MCHC	32.4	L g/dL		33.0 37.0
Plt	249.		x10^3/uL	150. 450.
LY%	14.3	*L %		20.5 51.1
LY#	2.0	* x10^3/uL		1.2 3.4

ID: [redacted] 19-09-03
WB 17:02

				Patient Limits
WBC	10.1	x10^3/uL		4.5 10.5
RBC	3.22	L x10^6/uL		4.00 6.00
Hgb	9.2	L g/dL		11.0 18.0
Hct	28.7	L %		35.0 60.0
MCV	88.9	fL		80.0 99.9
MCH	28.5	pg		27.0 31.0
MCHC	32.0	L g/dL		33.0 37.0
Plt	153.		x10^3/uL	150. 450.
LY%	17.6	*L %		20.5 51.1
LY#	1.8	* x10^3/uL		1.2 3.4

ID: [redacted] 19-09-03
WB 02:37

				Patient Limits
WBC	14.1	H x10^3/uL		4.5 10.5
RBC	4.12	x10^6/uL		4.00 6.00
Hgb	11.7	g/dL		11.0 18.0
Hct	36.1	%		35.0 60.0
MCV	87.5	fL		80.0 99.9
MCH	28.3	pg		27.0 31.0
MCHC	32.3	L g/dL		33.0 37.0
Plt	229.		x10^3/uL	150. 450.
LY%	24.3	* %		20.5 51.1
LY#	3.4	* x10^3/uL		1.2 3.4

ID: [redacted] 19-09-03
WB 01:39

				Patient Limits
WBC	15.9	H x10^3/uL		4.5 10.5
RBC	4.17	x10^6/uL		4.00 6.00
Hgb	11.5	g/dL		11.0 18.0
Hct	36.5	%		35.0 60.0
MCV	87.7	fL		80.0 99.9
MCH	27.5	pg		27.0 31.0
MCHC	31.4	L g/dL		33.0 37.0
Plt	288.		x10^3/uL	150. 450.
LY%	22.3	* %		20.5 51.1
LY#	3.5	*H x10^3/uL		1.2 3.4

i-STAT EG7+

Pt: [redacted] b(6)-4

Pt Name: b(6)-4

Na_____129 mmol/L
K_____3.9 mmol/L
TCO2_____27 mmol/L
iCa_____1.01 mmol/L
Hct_____38 %PCV
Hb*_____11 g/dL
*via Hct

At 37C
PH_____7.588
PCO2_____27.6 mmHg
PO2_____112 mmHg
HCO3_____26 mmol/L
BEecf_____5 mmol/L
sO2*_____99 %
*calculated

At Patient Temp
PH_____7.566
PCO2_____29.3 mmHg
PO2_____121 mmHg

Patient Temp: 101.1F
FIO2_____: 50
Sample Type_:

28SEP03 16:44

Oper: [redacted] b(6)-2
Physician:_____
Ser# [redacted]
Ver: [redacted]

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i-STAT EG7+

Pt: [redacted] b(6)-4

Pt Name: b(6)-4

Na_____131 mmol/L
K_____3.6 mmol/L
TCO2_____28 mmol/L
iCa_____1.00 mmol/L
Hct_____31 %PCV
Hb*_____11 g/dL
*via Hct

At 37C
PH_____7.450
PCO2_____38.4 mmHg
PO2_____85 mmHg
HCO3_____27 mmol/L
BEecf_____3 mmol/L
sO2*_____97 %
*calculated

At Patient Temp
PH_____7.425
PCO2_____41.3 mmHg
PO2_____94 mmHg

Patient Temp: 101.6F
FIO2_____: 55
Sample Type_:

28SEP03 04:56

Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: [redacted]

ID: [redacted] 28-09-03
WB b(6)-4 04:58

				Patient Limits
WBC	16.5	H	x10^3/uL	4.5 10.5
RBC	3.89	L	x10^6/uL	4.00 6.00
Hgb	10.7	L	g/dL	11.0 18.0
Hct	33.9	L	%	35.0 60.0
MCV	87.3		fL	80.0 99.9
MCH	27.5		pg	27.0 31.0
MCHC	31.5	L	g/dL	33.0 37.0
Plt	409.		x10^3/uL	150. 450.
LY%	7.6	*L	%	20.5 51.1
LY#	1.7	*	x10^3/uL	1.2 3.4

ID: [redacted] 28-09-03
WB b(6)-4 10:52

				Patient Limits
WBC	14.5	*H	x10^3/uL	4.5 10.5
RBC	3.81	L	x10^6/uL	4.00 6.00
Hgb	10.4	L	g/dL	11.0 18.0
Hct	33.6	L	%	35.0 60.0
MCV	88.2		fL	80.0 99.9
MCH	27.2		pg	27.0 31.0
MCHC	30.9	L	g/dL	33.0 37.0
Plt	395.		x10^3/uL	150. *450.
LY%	9.2	*L	%	20.5 51.1
LY#	1.3	*	x10^3/uL	1.2 3.4

ID: [redacted] 28-09-03
WB b(6)-4 23:12

				Patient Limits
WBC	13.3	H	x10^3/uL	4.5 10.5
RBC	3.81	L	x10^6/uL	4.00 6.00
Hgb	10.4	L	g/dL	11.0 18.0
Hct	33.4	L	%	35.0 60.0
MCV	87.7		fL	80.0 99.9
MCH	27.3		pg	27.0 31.0
MCHC	31.1	L	g/dL	33.0 37.0
Plt	410.		x10^3/uL	150. 450.
LY%	7.9	*L	%	20.5 51.1
LY#	1.1	*L	x10^3/uL	1.2 3.4

ID: [redacted] 28-09-03
WB b(6)-4 16:46

				Patient Limits
WBC	14.9	H	x10^3/uL	4.5 10.5
RBC	4.05		x10^6/uL	4.00 6.00
Hgb	11.1		g/dL	11.0 18.0
Hct	35.4		%	35.0 60.0
MCV	87.4		fL	80.0 99.9
MCH	27.5		pg	27.0 31.0
MCHC	31.4	L	g/dL	33.0 37.0
Plt	430.		x10^3/uL	150. 450.
LY%	11.3	*L	%	20.5 51.1
LY#	1.7	*	x10^3/uL	1.2 3.4

ID: [redacted] 28-09-03
WB b(6)-4 00:14

				Patient Limits
WBC	18.2	H	x10^3/uL	4.5 10.5
RBC	3.84	L	x10^6/uL	4.00 6.00
Hgb	10.6	L	g/dL	11.0 18.0
Hct	33.7	L	%	35.0 60.0
MCV	87.9		fL	80.0 99.9
MCH	27.5		pg	27.0 31.0
MCHC	31.3	L	g/dL	33.0 37.0
Plt	405.		x10^3/uL	150. 450.
LY%	7.0	*L	%	20.5 51.1
LY#	1.3	*	x10^3/uL	1.2 3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 11:13 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.2 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.28
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :11:11 PM
Card Lot :040302
Operator : [redacted]

b(6)-4

RAPIDPOINT COAG ANALYZER V4.54
[redacted] 09/28/03 04:47 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
~~Calculated INR = 1.31~~
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :04:46 PM
Card Lot :040302
Operator : [redacted]

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 11:16 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 36.2 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :11:13 PM
Card Lot :100208
Operator : [redacted]

b(6)-4

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 04:50 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 26.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :04:47 PM
Card Lot :100208
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 12:22 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.7 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.21
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :12:21 AM
Card Lot :040302
Operator : [redacted]

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 05:00 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :05:00 AM
Card Lot :040302
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
[redacted] 09/28/03 10:55 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.31
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :10:53 AM
Card Lot :040302
Operator : [redacted]

b(6)-4

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 12:25 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 32.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :12:22 AM
Card Lot :100208
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 05:04 AM

b(6)-4

Patient ID: [redacted]
Test Name :APTT
Test Result:= 31.0 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :05:02 AM
Card Lot :100208
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/28/03 10:58 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 31.1 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/28/03
Test Time :10:56 AM
Card Lot :100208
Operator : [redacted]

b(6)-2